Alabama Kidney Foundation, Inc. Alabama Transportation Assistance Program

PO Box 12505 , Birmingham, AL 35202
1.800.750.3331 or 1.205.934.2111; fax
1.205.975.6682; web ALKidney.org

Alabama Transportation Assistance Program (ATAP)

ENROLLMENT APPLICATION

Date of Application: _____ / ____ /____

PATIENT INFORMATION

Patient's Name: _____
First name Middle name Last name

Patient's Address:_____
Street

_____
City State Zip County

Social Security Number: _____ - _____ - _____ Home Phone: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: [ ] Male [ ] Female

Race: (African American) _____ Cauc)_____(Hisp)_____(Asian)_____(Amer. Ind.)_____ Other)_____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Dependents: [ ] No [ ] Yes If "Yes", give gender and age of each_____

Dialysis Unit Serving Patient: _____

Dialysis Unit Address:_____
Street City State Zip

Dialysis Unit Telephone Number: _____ FAX Number: _____

Social Worker (print name): _____

Please check:
[ ] Enrollment Application (All information requested is essential for enrollment in the program.)
[ ] Sources of Income and Expenses (Include verification for all income.)
[ ] Verification of Information

Social Worker should assist patient to ensure the form is as complete and accurate as possible.

SOURCES OF INCOME AND EXPENSES FORM

Patient's Name: _____ Patient's Social Security Number ____ - ____ -_____

MONTHLY INCOME

Gross Household Salary	[ ] Currently Employed	$ _____
	[ ] Spouse Employed	$ _____
	[ ] Other Employed Adult Living in Home	$ _____
	[ ] Not Currently Employed	
	[ ] Never Worked Outside Home	
Social Security or SSI	[ ] Yes	$ _____
	[ ] Pending	
	[ ] Not Eligible	

Comments: _____

_____

Social Security Disability	[ ] Yes	$ _____
	[ ] Pending	
	[ ] Not Eligible	

Comments: _____

_____

IRA	[ ] Yes	$ _____
Pension	[ ] Yes	$ _____
Retirement	[ ] Yes	$ _____

Comments: _____

_____

Other Income/Financial Resources:

(EXAMPLES INCLUDE: Child Support, Alimony, Company Disability, Medicaid NET,, Aid to Dependents, Veteran's Benefits, Dividend and Interest Income, Rental Income, etc.)

Please Specify and Explain _____ $ _____
_____ $ _____
_____ $ _____

TOTAL MONTHLY INCOME: **$** _____

ASSETS

Checking Account Value $ _____
Bank Name:_____
IRA $ _____
Home $ _____
Car $ _____

Other Assets

Please Specify and Explain _____ $ _____

TOTAL ASSETS $ _____

SOURCES OF INCOME AND EXPENSES FORM

Patient's Name: _____ Patient's Social Security Number ____ - ____ -_____

MONTHLY EXPENSES

[ ] Rent[ ] Mortgage	$ _____
Utilities	
Electricity	$ _____
Gas	$ _____
Water	$ _____
Telephone	$ _____
Cable	$ _____
Food	$ _____
Household Expenses	$ _____
Clothing	$ _____
Insurance	$ _____
Health	$ _____
Life	$ _____
Automobile	$ _____
Burial	$ _____
Homeowner's/Renter's	$ _____
Other	$ _____
Automobile	$ _____
Payment	$ _____
Gasoline	$ _____
Maintenance	$ _____
Monthly Travel Costs of Dialysis	$ _____
Medication	$ _____
Monthly Cost (including Co-Pay)	$ _____
Other Family Member's Medication Costs	$ _____
Miscellaneous	
Loan Payments	$ _____
Charge Accounts	$ _____
Medical Supplies	$ _____
Cell Phone/Pager	$ _____
Child Support	$ _____
Alimony	$ _____
Child Care	$ _____
Education (Student Only)	$ _____
TOTAL MONTHLY EXPENSES	$ _____

If monthly expenses exceed monthly income by $200 or more, please explain:

_____

_____

_____

VERIFICATION OF INFORMATION

Patients Name: _____ D ate: ____/_____/_____

THIS FORM MUST ACCOMPANY EACH FINANCIAL ASSISTANCE REQUEST WITH REQUIRED SIGNATURES.

Financial Assistance Program Goal and Measure
The goal of the Alabama Kidney Foundation's financial assistance programs is to help patients avert financial hardships so that they can experience life to its fullest. The program's effectiveness is affirmed by feedback from the patient and assisting social worker. This feedback comes through responses to our questions under Outcome Measures.

OUTCOME MEASURES

(Please ask the patient the following questions and record responses.)

Will the financial assistance ease a financial hardship? ____ Yes ____ No
Will the financial assistance help to improve your quality of life? ____ Yes ____ No

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Medicaid Non-Emergency Transportation Program
Statement of Ineligibility verified by Social Worker and Unit Director

The patient, _____, is **NOT** eligible for Alabama
Print patient's name
Medicaid Non-Emergency Transportation (NET). The Alabama Medicaid NET Assistance Program Regional Coordinator is a reliable source for verification purposes.

Authorization to Release Information

I hereby authorize the release to the Alabama Kidney Foundation, Inc. of any information available on the condition of myself, my spouse or my children as required to properly evaluate my application for financial assistance. I also agree that the information in this application may be verified.

Authenticity of Information

In submitting this application, I attest the accuracy and truth of the information with the intent that it be relied upon by the Alabama Kidney Foundation in considering assistance to the best of my ability.

REQUIRED SIGNATURES

Patient Signature: _____ Date: ____/_____/____

Social Service Professional: _____ Date: ____/____/_____

Unit Director: _____ Date: ____/_____/____