KNIGHTS OF COLUMBUS
NEW HAMPSHIRE STATE COUNCIL

KIDNEY FUND PROGRAM APPLICATION

Please Note: To be considered for the Kidney Fund Program, the Applicant must answer every question on this form. Failure to do so may result in denial of assistance. Questions that do not apply to you: write in **0**, **none**, or **n/a**. False information will be grounds for immediate termination of Program Benefits. Applicant must be a full time NH resident.

For Official Use Only

PHARMACY

Name:

Address:
City:

Phone: ( ) -

Our Privacy Policy: You have a right to know what we do with the information that we collect about you. We need accurate, current health and financial data so that we can determine your need for assistance. We may discuss your information with the case worker, pharmacy, and doctor that are indicated on this application. Your information will be shared within our organization only by those with the responsibility of determining the need and level of assistance available. We will protect all information provided on this document by physical, electronic, and procedural safeguards. Above all we value your trust and confidence in our ability to manage and protect your important personal information. If you have any questions concerning this policy you may contact the **State Secretary, New Hampshire Knights of Columbus.**

Part 1

APPLICANT:

Last Name:	**First Name:**	**Middle Initial**:	**Phone**: ( ) -
Gender: ☐ Male ☐ Female	**Date of Birth:** (Month/Day/Year) / /		**SSN**: - -
Address:	**City/Town:**	**State:**	**Zip:**
How long have you lived at this address?:	Years	Months	
If less than 3 years, list previous address(es):	**1)**		
	2)		
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	**Spouse Name:**		

LIST ALL PERSONS RESIDING WITH YOU:

Last Name:	First Name:	Middle Initial	Relation to Applicant
1.			
2.			
3.			
4.			
5.			

Income:

List income received by yourself, spouse, and all individuals residing with you who contribute toward your support. In addition, be sure to include all other income provided to you by individuals who do not reside in you home.

a) Have you applied to Social Security, Veterans, other benefits or pensions?: ☐ Yes ☐ No	
If Yes, identify the source of income:	
Presently receiving that income?: ☐ Yes ☐ No	**(Project Start Date**: Month: Year:)

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b) Type of Income:	**Total**	**Amount to your support**
Monthly gross wages:	$ .00	$ .00
Monthly supplemental Social Security benefits:	$ .00	$ .00
Monthly income from individuals residing in your home:	$ .00	$ .00
Monthly income from individuals not residing in your home:	$ .00	$ .00
Monthly income received as contributions:	$ .00	$ .00
Monthly income earned by caring for foster children:	$ .00	$ .00
Monthly income from annuities / trusts:	$ .00	$ .00
Monthly income from unemployment conpensation:	$ .00	$ .00
Monthly income from railroad pensions:	$ .00	$ .00
Monthly income from veterans' benefits:	$ .00	$ .00
Monthly income from county welfare:	$ .00	$ .00
Monthly income from state welfare:	$ .00	$ .00
Monthly income from city / town:	$ .00	$ .00
Monthly income from insurance benefits:	$ .00	$ .00
Monthly income from workmen's compensation:	$ .00	$ .00
Monthly income from pension benefits:	$ .00	$ .00
Monthly income from all other source(s), list each:		
1.	$ .00	$ .00
2.	$ .00	$ .00
3.	$ .00	$ .00

c) Are you receiving payment for an accident claim other than workmen's compensation?: ☐ Yes ☐ No

If yes, List amount: $ .00 **This amount is**: ☐ One total payment ☐ Monthly ☐ Weekly ☐ Annually

Name of company making payment on accident claim:

Date of Accident: (Month/Day/Year) / /

d) Do you own your own home?: ☐ Yes ☐ No	If yes, approximate market value: $ .00

e) Do you own any other property?: ☐ Yes ☐ No If yes, Describe below

Type of Property:(building type, # of acres, etc.)	**Approximate market value:**
1)	$ .00
2)	$ .00
3)	$ .00

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RESOURCES: Complete the following, listing all resources that you or your spouse and anyone for who assistance is being requested here. Under **"VALUE"** indicate the monetary worth of each item.

TYPE	VALUE	IN NAME(S) OF
Bank Savings:	$ .00	
Bank checking:	$ .00	
Cash on Hand:	$ .00	
Stocks / Bonds:	$ .00	
Life insurance (face value):	$ .00	
Life Insurance (cash value):	$ .00	
Other (describe):	$ .00	
Other (describe):	$ .00	

MEDICAL INSURANCE: Are you covered by the following plans?

a) Medicare: Hospital – Part A : ☐ Yes ☐ No — Date coverage took effect:: (Month/Day/Year) / /

Medical – Part B : ☐ Yes ☐ No — Date coverage took effect:: (Month/Day/Year) / /

Prescription Drug – Part D : ☐ Yes ☐ No — Date coverage took effect:: (Month/Day/Year) / /

If you have not applied, explain why: _____

b) Private Medical Insurance : ☐ Yes ☐ No Certificate number:_____

Name of Company_____

c) Champus (Veteran's Medical benefits) ☐ Yes ☐ No ID Card number:_____

Retired: ☐ Yes ☐ No Active duty: ☐ Yes ☐ No

d) Secondary or Spouse medical insurance: ☐ Yes ☐ No Policy Number:_____

Name of Company:_____

Type of Insurance (describe):_____

WELFARE ASSISTANCE: Have you or your spouse or anyone in your household applied for the following:

1) State Welfare Assistance:	☐ Yes ☐ No	2) City/Town Welfare Assistance:	☐ Yes ☐ No
3) County Welfare Assistance:	☐ Yes ☐ No	4) MediAid (Welfare medical):	☐ Yes ☐ No

If benefits are currently being received by you or your spouse or anyone in your household for any of the above, indicate by number and list amount. 1) $ .00 2) $ .00 3) $ .00 4) $ .00

Name of person(s) receiving the benefit(s):_____

If you or your spouse or anyone in your household have been denied any of the above benefits, list the name of the person and indicate the reason for denial:

Name:_____ Reason_____

Name:_____ Reason_____

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ADDITIONAL INFORMATION: List the names and address for the following:

Spouse:_____ Address:_____

List all dependents:

NAME	ADDRESS	Relationship to You

Explain the type of help you are requesting from the Knights of Columbus Kidney Fund (be specific):

Indicate the amount of financial assistance needed: $ .00 per quarter

List specific item(s) for which payment or assistance is being requested:

How long do you expect to need assistance (explain)?

Were you required to file federal income tax return forms last year?: ☐ Yes ☐ No
If yes, attach copies of all form(s) to this application

I certify that the above information is a true and complete statement of facts to the best of my knowledge and belief, under the penalty of unsworn falsification.

Applicant signature:_____Date_____

If applicable, the person who helped the applicant prepare this form must sign here.

Preparer signature:_____Date_____

(Review Committee notations and comments.)

_____

_____

_____

KNIGHTS OF COLUMBUS
NEW HAMPSHIRE STATE COUNCIL
KIDNEY FUND PROGRAM APPLICATION – Part II
PHYSICIAN CERTIFICATE

Name of physician completing this form: _____Date_____

Office address: _____Phone:_____

Patient Name:	Pharmacy name:
Address:	Address:
City/Town: State:	City/Town: State:
Zipcode: Phone	Zipcode Phone

NOTE: ANY UNANSWERED QUESTION WILL RESULT IN DISQUALIFICATION OF THIS APPLICATION

How long have you been treating the patient for kidney disease?:_____
Describe patient's condition:_____
_____
_____

Is patient disabled due to kidney disease? ☐ Yes ☐ No
If yes, how long will disability last?_____
Describe in general the treatment required for kidney disease: (dialysis, medication only, etc.)_____
_____
_____
How long do you expect treatment to be required?_____
List medication(s) [generic name] to be prescribed specifically for treatment of kidney disease for this patient:
_____
_____
_____
_____
How long do you expect medication to be required?_____
Is patient on dialysis machine?: If yes, location of machine?_____

Physician signature:_____

Name of social services representative:_____ Phone:_____
Email:_____
In your opinion, has the patient exhausted all efforts of available assistance such as Medicare, Medicaid, Private Medical Insurance, etc.? ☐ Yes ☐ No
Social representative signature_____ Date:_____

Mail Completed Application to:
NH State Council, Knights of Columbus
(603) 682-5318
gpcamley@gmail.com

Glenn P Camley, State Secretary
287 Daniel Webster Hwy.
Boscawen, NH 03303

As of 7-1-2016