WE MUST BE ABLE TO READ ALL INFORMATION AND ALL QUESTIONS MUST BE ANSWERED
OR YOUR APPLICATION WILL NOT BE PROCESSED

KDP Use Only:

ID# _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
KIDNEY DISEASE PROGRAM
APPLICATION FOR BENEFITS:

Part 1. **APPLICANT INFORMATION** PLEASE TYPE OR PRINT CLEARLY

Last Name	First Name	Middle I.	Date of Birth	Sex	Race (White ☐ Black ☐ Other ☐)

Address	County	City & State	Zip Code

Applicant's Social Security Number _____ Telephone Number _____

U.S. Citizen: ☐ Yes ☐ No If no, send a copy of your GREEN card, or other proof of permanent residency.

Permanent Maryland Resident: ☐ Yes ☐ No

MEDICAL INFORMATION TO BE COMPLETED BY PHYSICIAN

Facility Affiliation (Complete Name)	Date of First Chronic Dialysis in Maryland	Primary Cause of Illness

Type of Treatment:
- Home Hemodialysis ☐
- Home IPD ☐ Home CAPD ☐ Home CCPD ☐
- Dialysis In-Center ☐
- Transplantation ☐ Date _____

Signature of Physician	Date	Telephone Number

Name of Physician (Please Print) _____

HEALTH INSURANCE INFORMATION

Medicare "A"	☐ Yes	☐ No	ID# _____
Medicare "B"	☐ Yes	☐ No	ID# _____
Medicare "D" Rx	☐ Yes	☐ No	ID# _____
Medicaid	☐ Yes	☐ No	ID# _____

Private Insurance (Include Front & Back Copies of Insurance Card) (If None please indicate)

1. Insurance Co. _____ Address _____ Policy # _____

Policyholder	Group? Yes or No	Major Medical? Yes or No	Prescription Card? Yes or No	Effective Date

2. Insurance Co. _____ Address _____ Policy # _____

Policyholder	Group? Yes or No	Major Medical? Yes or No	Prescription Card? Yes or No	Effective Date

Part 2. **FAMILY MEMBERS LIVING WITH YOU** (Attach a separate sheet if necessary)

Spouse	Last Name	First Name	Middle I.	Date of Birth
Child (under 21)	Last Name	First Name	Middle I.	Date of Birth
Child (under 21)	Last Name	First Name	Middle I.	Date of Birth
Child (under 21)	Last Name	First Name	Middle I.	Date of Birth
Mother (If you are under 21)	Last Name	First Name	Middle I.	Date of Birth
Father (If you are under 21)	Last Name	First Name	Middle I.	Date of Birth

PLEASE TURN THE PAGE, MORE ON THE OTHER SIDE.

READ INSTRUCTIONS **PLEASE PRINT CLEARLY** **ANSWER ALL QUESTIONS** **FILL EMPTY SPACES WITH "O"**

Part 3. **INCOME:** List annual adjusted gross income amounts as reported on the previous year's Federal Tax returns filed by you and your family. Also list the gross amounts of Social Security benefits and Tier 1 Railroad Retirement benefits and/or any other Pensions or Annuities not included as annual adjusted gross income on the Federal Tax returns of you and your family. Fill out a column for each person. Enter zero (0) in the appropriate spaces if you or your family members have no such income. In listing annual income amounts of family members, be sure to identify who received the income amounts. You must attach copies of the previous year's Federal Tax returns, with all accompanying schedules, W2's & 1099's, etc., filed by you and your family. Also attach copies of the current Social Security benefit letter(s) and Tier 1 Railroad Retirement benefit letter(s) and/or any other Pensions or Annuities received by you and your family.

	APPLICANT	SPOUSE (if living with you)	CHILDREN UNDER 21 (if living with you)	PARENTS (if applicant is under 21 & living with parents)
A. ADJUSTED GROSS INCOME - State the annual adjusted gross income amounts reported on the previous year's Federal Income Tax returns of you and your family. Attach copies of the previous year's Federal Tax returns and all accompanying schedules of you and your family, including W2's & 1099's to match return. If you or a member of your family did not file a Federal Income Tax return for the previous calendar year, please explain why:				
B. SOCIAL SECURITY BENEFITS - State the current gross amount of annual Social Security benefits before Medicare deductions. For each person receiving Social Security, attach a copy of his/her Social Security benefit letter showing the current monthly gross amount of entitlement.				
C. PENSIONS OR ANNUITIES TO INCLUDE TIER 1 RAILROAD RETIREMENT BENEFITS & VA - State the annual current gross amount received of these benefits. For each person receiving Pensions and/or annuities, including Tier 1 Railroad Retirement benefits & VA, attach a copy of his/her benefit letter showing the current monthly gross benefit amount.				
D. SIGNIFICANT CHANGES TO ADJUSTED GROSS INCOMES - If you or one of your family members is no longer employed and/or the annual adjusted gross income amounts of you or one of your family members has changed significantly from the amounts reported on your previous year's Federal Tax returns, please indicate amounts of such income in the appropriate column and explain the changes to your family income in the space provided. **Attach 4 current, consecutive pay stubs for each person employed.**				

READ INSTRUCTIONS **PLEASE PRINT CLEARLY** **ANSWER ALL QUESTIONS** **FILL EMPTY SPACES WITH "O"**

Part 4. **LIQUID ASSETS:** Describe the liquid assets of you and your family. Fill out a column for each person. Enter zero (0) in the appropriate spaces if you or your family members have no such assets. If you share an asset with someone else, fill in how much belongs to you. For assets belonging to family members, identify which family **member** owns the asset. Attach copies of statements showing current balances and/or cash value of all assets listed below.

	APPLICANT	SPOUSE (if living with you)	CHILDREN UNDER 21 (if living with you)	PARENTS (if applicant is under 21 & living with parents)
A. CASH - Fill in how much money each person has in cash or in a checking account. Print the name of the bank and the account number, in the appropriate column. Attach current, complete statement showing at least 30 days of transactions.				
B. SAVINGS ACCOUNT - Fill in how much each person has in savings accounts, and certificates of deposit. Print the name of the bank and the account number, in the appropriate column. Attach current, complete statement showing at least 30 days of transactions.				
C. STOCKS, BONDS, MUTUAL FUNDS AND IRA'S - Fill in the cash value of stocks, bonds, mutual funds, IRA's and/or money market accounts that each person owns. List names of any co-owners. Attach current statements.				
D. LIFE INSURANCE - List the cash value of each life insurance policy each person owns if the amount is over $1500. Call your insurance agent to find out the cash value. Do not list policies that are payable upon death only. Attach current statements.				

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IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE STATEMENT BELOW. IF YOU DO NOT UNDERSTAND IT, CONTACT YOUR RENAL COORDINATOR OR SOCIAL WORKER AT YOUR DIALYSIS FACILITY OR THE KIDNEY DISEASE PROGRAM AT (410) 767-5000.

This is to certify that the foregoing is true, accurate, and complete to the best of my knowledge, information, and belief. I understand that I or my legal representative may be asked to give proof of the foregoing statements to a representative of the Kidney Disease Program, or to give additional information to complete this application. I also understand that anyone named in this application may be required by any authorized representative of the State government to verify that these facts are indeed true, correct, and complete.

I hereby authorize any financial institution, insurance company, present or past employer, federal, state, or local governmental agency, or any other private or public organization to furnish upon request to the Kidney Disease Program any information contained in their records regarding the citizenship, residency, income, assets, and health insurance coverage of myself, my spouse, and my children under 21.

I hereby authorize any certified facility, physician, clinic, or other person who has provided service to me to furnish to the Kidney Disease Program, or its representative, any and all medical information and copies of all medical records pertaining to same. Furthermore, I authorize the Kidney Disease Program to release such information to my insurance carrier for the purpose of obtaining benefits. In addition, authorization is hereby given to my insurance carrier to make payment directly to the Kidney Disease Program of the benefits otherwise payable to me.

I understand that this signed statement serves as written authorization for any of the above organizations or persons to release the information described.

I or my representative will report at once in writing any change in my income, liquid assets, employment, family group, and/or address and telephone number to the Kidney Disease Program.

I understand that I must inform any provider of kidney disease services of any other health insurance I have at the time I present my Kidney Disease Program card to that provider.

SIGNED _____ DATE _____

Applicant or Representative (Relationship to Applicant)

WITNESS REQUIRED ONLY IF APPLICANT SIGNS WITH "X"

WITNESS _____ DATE _____

BEFORE YOU MAIL THIS APPLICATION, DID YOU:

☐ ATTACH COPIES OF THE PREVIOUS YEAR'S FEDERAL INCOME TAX RETURNS OF YOU AND YOUR FAMILY?

☐ ATTACH COPIES OF THE SOCIAL SECURITY BENEFIT LETTER(S), PENSION OR ANNUITY INCLUDING TIER 1 RAILROAD RETIREMENT BENEFIT & VA LETTER(S) FOR YOU AND/OR YOUR FAMILY.

MAIL TO:

KIDNEY DISEASE PROGRAM
201 WEST PRESTON STREET
ROOM SS 3
BALTIMORE, MD 21201
PHONE (410) 767-5000

KDP Use Only:

Based on information herein which is complete and accurate to the best of my knowledge, this application is:

APPROVED _____ INITIALS _____ DATE _____

DENIED _____ INITIALS _____ DATE _____