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#_____

MARYLAND DEPARTMENT OF HEALTH
KIDNEY DISEASE PROGRAM
APPLICATION FOR BENEFITS

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

White ☐ Black ☐ Other ☐

Last Name | First Name | Middle I. | Date of Birth | Sex | Race

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 **(INCLUDE COPIES OF FRONT & BACK OF ALL CARDS)**

Medicare "A" ☐ Yes ☐ No ID# _____

Medicare "B" ☐ Yes ☐ No ID# _____

Medicare "D" Rx ☐ Yes ☐ No ID# _____

Medicaid ☐ Yes ☐ No ID# _____

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

1. Insurance Co. _____ Address _____ Policy # _____

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

2. Insurance Co. _____ Address _____ Policy # _____

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

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

	Spouse	Last Name	First Name	Middle I.	Date of Birth

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

s 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 fits 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 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 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. ırity 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	CHILDREN UNDER 21 (if living with you)	PARENTS (if applicant is under 21 & living with parents)
ːate the annual adjusted gross income amounts reported on the turns of you and your family. Attach copies of the previous year's ing schedules of you and your family, including W2's & 1099's to ɔur family did not file a Federal Income Tax return for the previous				
State the current gross amount of annual Social Security benefits ɔerson receiving Social Security, attach a copy of his/her Social ɜnt monthly gross amount of entitlement.				
ICLUDE TIER I RAILROAD RETIREMENT BENEFITS & unt received of these benefits. For each person receiving ɛr I Railroad Retirement benefits & VA. attach a copy of his/her ıly gross benefit amount.				
JUSTED GROSS INCOMES - If you or one of your family the annual adjusted gross income amounts of you or one of your ıtly from the amounts reported on your previous year's Federal such income in the appropriate column and explain the changes to ed. **Attach 4 current**, consecutive **pay stubs for each person**				

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

ıuid 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.
ın how much belongs to you. For assets belonging to family members, identify which family **member** owns the asset. Attach copies of statements showing
ːts listed below.

	APPLICANT	SPOUSE	CHILDREN UNDER 21 (if living with you)	PARENTS (if applicant is under 21 & living with parents)
ıch person has in cash or in a checking account. Print the name of e appropriate column. Attach current, complete statement s.				
much each person has in savings accounts, and certificates of the account number, in the appropriate column. Attach current, days of transactions.				
DS AND IRA'S - Fill in the cash value of stocks, bonds, mutual ınts that each person owns. List names of any co-owners.				
ːalue of each life insurance policy each person owns if the ıce agent to find out the cash value. Do not list policies that are ː statements.				

PLEASE TURN THE PAGE, MORE ON THE OTHER SIDE.

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:

- ☐ Include copies of the previous year's federal income tax return for you and your family
- ☐ Include copies of the social security benefit letters, pension & annuity statements including Tier I Railroad retirement benefits & VA letters for you and your family.
- ☐ Include copies of the front & back of your Medicare, Parts A, B & D, Maryland Medicaid & private health insurance cards, if applicable.

MAIL TO:

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