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nkfi@kidneyindiana.org www.kidneyindiana.org

Date _____

Name and Position of Requester (e.g. Social Worker, Physician, Dialysis Transplant Center)

Address _____

City, State, Zip _____ County _____

Phone _____ Fax _____

E-mail _____

Patient Name _____ Patient Age _____

Address _____

City, State, Zip _____ County _____

Phone _____ Ethnicity (e.g. African American, Caucasian, Hispanic, Native American, Pacific

Islander, Asian, Other) _____

Amount Requested _____

Describe the need. Attach appropriate documentation (e.g. bill/invoice):

How will patient address future payment of this issue?

List assistance sources solicited and whether approved or denied. Include reason for denial.

Make check payable to: _____

Address _____

City, State Zip _____

Phone _____ Account number : _____

NKFI Office use only:

Please mark which fund: Lassus _____ Jeevan _____ General _____