Arkansas Department of Health

Kidney Disease Program

4815 W. Makrham St. Slot 35 | Tel: 501-686-2807 | Fax: 501-686-2831

Initial Referral Application

Date: _____ **Pre-Transplant Dental Assistance Only:** Yes ☐ No ☐

Client/Patient Information:

First Name	*Last Name*		*Middle Initial*
Social Security Number	*Date of Birth (mm/dd/yyyy)*	*Race*	*Sex* Male ☐ Female ☐
Physical Street Address			
City	*State* **AR**	*Zip Code*	*County*
Mailing Address (if different from above)	*City*	*State* **AR**	*Zip Code*
Phone Number	*Contact Person*	*Contact Person Phone Number*	
Date of first dialysis (mm/dd/yyyy)	*Date of transplant (mm/dd/yyyy)*	*Where does dialysis take place?* ☐ In Center ☐ At Home	
Other medical conditions			

☐ ☐

Insurance Information:

Client has Medicare Health Benefits? Yes ☐ No ☐ Medicare #: _____ Drug coverage? Yes ☐ No ☐

Client has Medicaid Health Benefits? Yes ☐ No ☐ Medicaid #: _____ Drug coverage? Yes ☐ No ☐

Client has Private Health Insurance? Yes ☐ No ☐ Does this include drug coverage? Yes ☐ No ☐

Client has Veteran's Health Benefits? Yes ☐ No ☐ Does this include drug coverage? Yes ☐ No ☐

Dialysis/Social Worker Information:

Name of Social Worker		*Social Worker Email Address*	
Phone Number	*Facsimile Number*	*Dialysis Center/Facility*	
Street Address	*City*	*State* **AR**	*Zip Code*

Confidentiality of Information:

The information contained within this application concerning the person making application to the Arkansas Kidney Disease Program for services is considered personal and may be protected by both State and Federal laws and regulations. This information is to be treated with the highest degree of confidentiality and may only be exchanged to that minimally necessary to accomplish the provision of services or other Arkansas Kidney Disease Program operations consistent with the intent of applicable State and Federal statues.

I agree to protect and will only exchange this information consistent with applicable statutes.

_____

(Renal Social Worker's Signature)

I agree to protect and will only exchange this information consistent with applicable statutes. I certify this person has end stage renal disease.

_____

(Physician's Signature)

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Initial Referral Application-Pt. 2 Financial Needs

First Name	*Last Name*	*M.I.*	*SSN*

Financial Need:

Number of individuals living in household: _____

Complete financial information on total household members is required. Verification of financial information may be requested if questions exist.

Assets	**Amount(s)**	**Monthly Income**	**Amount(s)**
Checking Account(s)	$_____	Applicant's Net Wages	$_____
Savings Account(s)	$_____	Spouse's Net Wages	$_____
Rental Property	$_____	Additional Household Member Net Wages	$_____
Farm or Business	$_____	Social Security	$_____
Stocks/Bonds/CD's	$_____	SSI/SSDI	$_____
Other Liquid Assets	$_____	Retirement	$_____
		Veteran's Benefits	$_____
		Other (Specify)	$_____
Total Assets	**$_____**	**Total Household Income**	**$_____**

Confidentiality of Information:

I understand all personal information provided by me to the Arkansas Kidney Disease Program must be treated with the highest degree of confidentiality. I understand it may be necessary for some of my personal information to be exchanged between my renal social worker, physician, pharmacist, and/or dentist and the Program as part of my application for services, payment for services provided, or other program operations. It will be the responsibility of the Program and parties involved to respect my personal information and limit information exchanged to that minimally necessary to provide the services for which I am eligible.

When requested in writing, I understand the Kidney Disease Program will make available to me or, if appropriate, my representative, information contained in my case file. Should I or if appropriate, my representative believe the information contained in the file to be inaccurate or misleading, I may request the Kidney Disease Program to amend such information. I understand that my personal information will only be released with my permission, except for the following conditions: if another agency or organization requests personal information in response to investigations in connection with law enforcement, fraud and abuse, unless expressly prohibited by Federal and State laws or regulations, and in response to an order issued by a judge, magistrate, or other authorized judicial official. I hereby certify the information provided by me on this form is accurate and to the best of my knowledge. I also hereby acknowledge being informed of the Kidney Disease Program's requirement to maintain my personal information in a confidential manner and the conditions under which it can be made available or released.

_____ _____

Applicant Signature *Date*

Program Use Only	**Applicant is:** ☐ Eligible ☐ Ineligible for services	**Effective Date:** _____