



Arkansas Department of Health
Arkansas Kidney Disease Commission

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 <input type="checkbox"/> Female <input type="checkbox"/>		
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? <input type="checkbox"/> In Center <input type="checkbox"/> At Home			
Other medical conditions					

Should applicant be referred for Vocational Rehabilitation Services? Yes No

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 Commission (AKDC) 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 AKDC program operations consistent with the intent of applicable State and Federal statutes.

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

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

 (Renal Social Worker's Signature)

 (Physician's Signature)



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Initial Referral Application-Pt. 2 Financial Needs

<i>First Name</i>	<i>Last Name</i>	<i>M.I.</i>	<i>SSN</i>
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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 Commission (AKDC) 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 AKDC as part of my application for services, payment for services provided, or other program operations. It will be the responsibility of the AKDC 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 AKDC 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 AKDC 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 AKDC'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

AKDC Use Only	Applicant is: <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible for services	Effective Date: _____
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