



Arkansas Department of Health
Arkansas Kidney Disease Commission

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



Annual Renewal 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	

Current dialysis patient? Yes No Transplant patient? Yes No Date of transplant: _____

Status Change Information:

- Client has transferred out of state City: _____ State: _____ Effective date: _____
- Client has moved to residential facility Name of facility: _____ Effective date: _____
- Client has received a kidney transplant Name of transplant center: _____ Effective date: _____
- Client has regained kidney function Date of last dialysis treatment: _____ Effective date: _____
- Client has expired Date of death: _____

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			
Address		City	State AR	Zip Code	

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

 (Renal Social Worker's Signature) Date

 (Physician's Signature) Date



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<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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