

ARKANSAS KIDNEY DISEASE COMMISSION
REFERRAL APPLICATION

1 of 2

Arkansas Rehabilitation Services
Arkansas Kidney Disease Commission
26 Corporate Hill Drive
Little Rock, Arkansas 72205

Tel - (501) 686-2807
Fax - (501) 686-2831

Date: _____

Name: _____ Social Security #: _____

Date of Birth: _____ Race: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____ County: _____ Cd.: _____

Phone: (____) _____ Alternate Phone: (____) _____

Message/Contact Person: _____ Phone: (____) _____

Has applicant applied for Medicare? Yes No Medicare #: _____

Has applicant applied for Medicaid? Yes No Medicaid #: _____

Medicaid Program and Effective Date: _____ (Provide copies of Medicare and/or Medicaid cards, if avail.)

Applicant has Private Health Insurance? Yes No With medication coverage? Yes No

Applicant has Veteran's Health Benefits? Yes No With medication coverage? Yes No

Renal Social Worker: _____ Unit: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Should applicant be referred for Vocational Rehabilitation Services? Yes No

Date of first dialysis: _____ Dialysis takes place: In Center At Home

Date of transplant: _____ Medical Facility: _____

Other Medical Conditions: _____

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 exchange 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)

AKDC Use Only Applicant is: Eligible Ineligible for services. Effective Date: _____

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Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

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	\$ _____
Real Estate/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	\$ _____
TOTAL ASSETS	\$ _____	Other (Specify) _____	\$ _____
		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. 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