The Kidney Foundation of Central PA

PATIENT EMERGENCY ASSISTANCE FUND APPLICATION

Thank you for taking the time to complete this application to receive a distribution of funds for your patients. All information must be completed in full. Your responses will be kept confidential and will only be used to assist us with administration of the Patient Emergency Assistance Program.

Today's Date: _____

Name of Facility:_____

Address of Facility:_____

_____

City _____ Zip_____

Phone: _____ Fax: _____

Total Capacity: _____ **Total Current Patient Population**: _____

Average Daily Census: _____

Funds are allocated based on KFCPs Census-Adjusted Distribution Rubric.

Medical Director Name: _____

Name of Facility Administrator: _____

E-mail address: _____

Name of Social Worker Check Payee:_____

E-mail address: _____

RETURN VIA MAIL OR FAX:
KFCP Patient Emergency Assistance Fund Program
900 S. Arlington Ave., Suite 134A, Harrisburg, PA 17109
FAX: (717) 671-9444