



Please read before submitting a request:

The Angel Kidney Fund is a last resort for kidney patients. Be sure you have exhausted ALL possible resources before requesting assistance. A patient is eligible for up to \$250.00 per year. Amount is subject to change depending on funds. Requests of more than \$250 will be determined on a case by case basis. It is our policy not to make out checks to patients for any reason. It is our goal to process requests within 2 business days; however, errors made will result in a delay of the grant being processed.

Be sure to fill in form completely, submit proper receipts/bills, and check to make sure the information is correct.

Dialysis Unit/Hospital: _____

Address: _____
(include street, city, state and zip code)

Phone: (____) _____

Social Worker: _____

Patient's Name: _____

Patient's Address: _____

Patient's Phone #: _____

Date: _____

<p style="text-align: center;">Previous Funding</p> <p>Has patient previously received funding from the Angel Fund? <u>YES / NO</u></p> <p>If YES, was it within the last 12 months? <u>YES / NO</u></p>

REQUEST DETAILS: PROVIDER INFORMATION (name and address), AMOUNT & COMMENTS

Transportation: _____

Medication (name & Rx):

Nutritional Supplement:

Utility Bill (include account #):

Other (please specify): _____

Provider's Address:

Amount: \$_____

Make Check Payable To:_____

Address to Mail Check:

Patient's Signature: _____

By signing above, I give the Angel Kidney Fund, Inc. my authorization to review this information for grant funding purposes. I also understand that additional information may be requested.

Additional information/comments:

PLEASE Fax/Email or Mail Request to:

Stephanie Eiland
2716 Madison 7840
Wesley, AR 72273

479-444-0200 OFFICE
888-512-2112 FAX
info@kidneywalkathon.org

When faxing request, please email Stephanie to inform her to expect a fax. You can also scan the form & email it to Stephanie.

www.kidneywalkathon.org

Angel Kidney Fund, Inc.