Washington State Health Care Authority

Clear Form

Kidney Disease Program (KDP) Application for Eligibility

Instructions: *Please read each part carefully. Type or print your answers in the appropriate spaces. All spaces in Part I, Part II, and Part III must be completed.*

1. Name of the kidney center

Part I. Personal information

2. Name (first, middle initial, last)	3. Date of birth	4. Social Security number (SSN)

5. Mailing address

6. Home telephone number	7. Work telephone or cell number	8. Employer	9. Occupation

10. Sex
☐ Male
☐ Female

11. Ethnic Group (optional)
☐ Caucasian (white) ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian
☐ Other (specify) _____

12. List family members living in your household that you are financially responsible for. **Do not include yourself.**

Name	Date of birth	Relationship	Social Security number (SSN)

Part II. Third party coverage (answer all of the following questions)

1. Are you covered by Medicare? **Part A?** ☐ Yes ☐ No **Part B?** ☐ Yes ☐ No

2. Do you have a Medicare supplement ***or*** other health insurance? ☐ Yes ☐ No
If yes, name of insurance: Group number: ID number:

3. Have you applied for Washington Apple Health (Medicaid) in the last 6 months? ☐ Yes ☐ No
If yes, mark the determination letter you received below and attach a copy.

☐ Approval letter: you qualified to receive Washington Apple Health.
☐ Approval letter: you are eligible to enroll in a Qualified Health Plan (QHP).
Name of QHP: _____ Monthly premium: $ _____
☐ Denial letter: you did not qualify for Washington Apple Health.
☐ Applicant Liability: you did not qualify because of a spenddown liability.
Enter the dollar amount of spenddown liability: $ _____ ☐ for three (3) months ☐ for six (6) months
☐ Other (specify): _____

Part III. Income and Resources

Annual Family Household (Enter Annual Totals For All Items)

Earned Annual Income	**Self**	**Spouse/Other**	**Resources**	**Self**	**Spouse/Other**
1. Gross Annual Salary/Wages			1. Checking, Savings, IRAs, etc.		
2. 50% Gross Income Disregard			2. Stocks and Bonds		
Unearned Annual Income	**Self**	**Spouse/Other**	3. Contracts		
3. Disability Insurance (Social Security, Private, or Government)			4. Other Real Estate Excluding Primary Home (Attach Tax Assessment)		
4. Social Security Retirement			5. Annuities		
5. Retirement Pension			6. Insurance (Cash Value)		
6. Business Property, Rental Income			7. Personal Property Excluding Primary Vehicle		
7. Interest (Savings, etc.)			7a. Car 2 (Specify Model/Year)		
8. Dividends and Royalties			7b. Car 3 (Specify Model/Year)		
9. Child Support Received			8. Other Vehicle Types (Specify - Boats, Motorcycles, RVs, etc.)		
10. Unemployment Compensation					
11. Public Assistance			9. Value of Assets Given Away (Previous 2 Years)		
12. Other (Specify)			10. Court Ordered Awards		
13. Unearned Income Disregard (Explain)			11. Non-medical Insurance Benefits		
14. Total Earned Income (Line 2)			12. Other (Specify)		
15. Total Unearned Income (Sum lines 3 through 13)			13. Total Resources (Sum lines 1 through 12)		
Total Combined Income (Sum lines 14 and 15)			**Total Combined Resources** (Line 13)		

Explanation/Remarks (Please Print)

I assign this Kidney Center my rights to any third-party payments to pay for covered medical services while I receive medical assistance. I declare under penalty of perjury that the information given by me in this declaration is true, correct, and complete to the best of my knowledge. I will promptly notify the Kidney Center of any substantial change in my income or resources. I realize that willful falsification of this information may make me ineligible to receive help with my medical bills. I agree to send copies of IRS forms or other verification, if requested.

Signature of Applicant or Legal Guardian (Print Only – No Electronic Signatures)	Date

Kidney Center Use Only

KDP client status Client is: ☐ New ☐ Reapplying ☐ Update to current eligibility information	Client is eligible for KDP assistance. Starting _____ Through _____

I hereby certify that the applicant is eligible according to information provided on the Application for Eligibility, HCA 13-566, as set forth in WAC 182-540 and the Kidney Disease Program manual.

Signature of Kidney Center Official (Print Only – No Electronic Signatures)	Date