Washington State Health Care Authority

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

5. Mailing address

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

10. Sex
Male ☐
Female ☐

11. Race (optional)
☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other

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?
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 3 months ☐ For 6 months
☐ Other:

Part III. Income and resources					
Annual Family Household (enter annual totals for all items)					
Earned Annual Income	**Yours**	**Spouse/other**	**Resource**	**Yours**	**Spouse/other**
1. Gross annual salaries/wages			1. Checking, Savings, IRAs, etc.		
2. 50% gross income disregard			2. Stocks, Bonds		
Unearned Annual Income	**Yours**	**Spouse/other**	3. Contracts		
3. Disability insurance (Social Security, private or government)			4. Other Real Estate - Attach tax assessment		
4. Social Security retirement			Do not include primary home.		
5. Retirement pension			5. Annuities		
6. Business property, rental income			6. Insurance (cash value)		
7. Interest (savings, etc.)			7. Personal Property. Do not include primary vehicle.		
8. Dividends, royalties					
9. Child support received			Car 2: model/year		
9. Unemployment compensation			Car 3: model/year		
10. Public assistance					
11. Other (specify):			Other vehicles (boats, motorcycles, RVs)		
12. Unearned income disregard			Type:		
Describe income disregard:			8. Other resources		
			Value of assets given away (in the last 2 years)		
Total earned income (line 2)			Court ordered awards to you		
Total unearned income			Nonmedical insurance benefits		
Total income			Other (specify)		
			Total resources (add lines 1 to 8)		
Total combined income			**Total combined resources**		

Explanation/remarks (please type or 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 eligible for KDP assistance.
Client is: ☐ New ☐ Reapplying	Starting _____
☐ Update to current eligibility information	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