Patient Insurability Assessment

Complete in **entirety** and fax to 866-720-0766 to begin processing

Patient Name: _____ **Patient DOB:** _____

Diagnosis: ❒ Acute Renal Failure ❒ New to ESRD ❒ Established ESRD Patient
FDODE: _____ Previous Clinic Name & Location: _____

Citizenship: ❒ US Citizen ❒ Permanent Resident/Visa
❒ Citizen of Micronesia, Marshall Island, or Palau ❒ Undocumented

If Permanent Resident/Visa*
SSN: _____ Effective date of residency: _____ Expiration date of residency: _____
**Please provide a copy of proof of residency (i.e. Perm resident card, Green card, and/or Visa)*

If citizen of Micronesia, Marshall Islands, or Palua do they have:
❒ Current Passport ❒ I-94 (Arrival Record)

If Undocumented: ❒ ITIN ❒ None
Effective Date of ITIN: _____ Expiration date of ITIN: _____ Please Provide proof ITIN

State Residency: Current state of residence: _____ Length of residency in that state, in years: _____

Work Status: Total number of years worked and paid US taxes: _____
(please specify the number of years including half-years, if applicable):

❒ Actively employed and has access to an EGHP
❒ Actively employed and NO access to an EGHP
❒ Not actively employed; last date worked paying US taxes:
❒ Never worked: _____

Disabled: Entitlement Reason: _____

Income, etc: Annual income (pre-tax): _____ If zero income, how are you supporting yourself? _____
Dollar Value of bank accounts, retirement accounts, stocks, & bonds: _____
Household size*: Number of dependent children <19 years of age: _____
**The household size is the number of persons for whom you are financially responsible*

Marital Status: ❒ **Single** ❒ **Married** ❒ **Separated**

Married/Significant Other; please specify:
- ❒ Spouse/Significant Other employed with insurance coverage through employer
- ❒ Spouse/Significant Other employed with no insurance coverage
- ❒ Spouse/Significant Other not actively employed
- ❒ Spouse/Significant Other with work history >10 years (AND paid US taxes)

If Under 26:
- ❒ Parent/Guardian employed with insurance coverage through employer
- ❒ Parent/Guardian employed with no insurance
- ❒ Parent/Guardian not actively employed
- ❒ Parent/Guardian formerly employed with work history >10 years (AND paid US taxes)

Medical Coverage: Has the patient applied for coverage or have a pending application within the past 90 days? ❒ Yes ❒ No
If **yes**, what coverage has been applied for? _____
And **when** was the application submitted? _____
Has the patient had previous medical coverage? ❒ Yes ❒ No
If **yes**, was it: ❒ Previous Employer Group Health Plan
- ❒ Previous Individual Commercial Plan
- ❒ Previous Medicare Part B
- ❒ Previous Medicaid: **State**: _____

And **when** did this coverage terminate? _____

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Is the patient receiving benefits from the Railroad Retirement Board? ❒ Yes ❒ No

Is the patient currently incarcerated or in a halfway house? ❒ Yes ❒ No

Please provide any other details to summarize the patient's situation: _____

_____

_____

Path to insurability assessment determination *(internal use only)*

Completed by: _____ Date: _____

Determination: Medicare: ❒ Eligible ❒ Ineligible

Medicaid: ❒ Eligible ❒ Ineligible

Other: ❒ Eligible ❒ Ineligible

If "Other", eligible for what: _____

Determination Explaination: _____

_____

_____

_____