

**KIDNEY AND KIDNEY/PANCREAS  
 TRANSPLANT RECIPIENT APPLICATION**

**LEGAL NAME:** \_\_\_\_\_ **GENDER:**  Male  Female  
 (First) (MI) (Last) (Maiden)

**ADDRESS:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
 (Street) (Apt #)

\_\_\_\_\_  
 (City) (State) (Zip) **MARITAL STATUS:**  MARRIED  
 SINGLE  
 DIVORCED  
 WIDOWED

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **ALLERGIES:** \_\_\_\_\_

**TELEPHONE NUMBERS:** Home- (\_\_\_\_\_) \_\_\_\_\_ Cell- (\_\_\_\_\_) \_\_\_\_\_ Work- (\_\_\_\_\_) \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **VISUAL IMPAIRMENT:**  Yes  No **HEARING IMPAIRMENT:**  Yes  No

**EDUCATION COMPLETED:**  1st-8th grade  High School/GED  College 2 yrs  College 4 yrs  Graduate  N/A

**RACE:** \_\_\_\_\_ **U.S. CITIZEN:**  Yes  No If **No**, how many years have you lived in the US? \_\_\_\_\_

**ARE YOU OF HISPANIC ORIGIN:**  Yes  No **PRIMARY LANGUAGE SPOKEN:**  English  Spanish  Creole  Other

**CAN YOU READ ENGLISH:**  Yes  No **CAN YOU UNDERSTAND SPOKEN ENGLISH:**  Yes  No

**\*IF YOU DO NOT SPEAK OR UNDERSTAND ENGLISH, WE WILL ARRANGE FOR A MEDICAL INTERPRETER FOR ALL APPOINTMENTS\***

**ARE YOU EMPLOYED:**  Yes  No **IF YES, DO YOU WORK:**  Full Time  Part Time

**EMERGENCY CONTACTS:**

**Name:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_  
**Home Tel#:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_  
**Home Tel#:** \_\_\_\_\_  
**Cell #:** \_\_\_\_\_

**PHYSICIANS:**

**Primary Care:** Name: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_  
**Nephrologist:** Name: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_  
**Cardiologist:** Name: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_

**Completed Application and Required records can be sent by mail or fax to:**

**\*\*\*ALL INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE SENDER\*\*\***

**By Mail:** Florida Hospital Transplant Institute  
 2415 North Orange Ave. Suite 700  
 Orlando, FL 32804

**By Fax:** 407-303-0677  
 407-303-2998

For Office Use Only: Medical Record #: \_\_\_\_\_

**HEALTH HISTORY:**

Please answer the following by putting a check mark in the appropriate box

High Blood Pressure Yes No

Sleep Apnea Yes No

Heart Disease Yes No

Asthma/Lung Disease Yes No

Cardiac Pacemaker Yes No

Tuberculosis Yes No

Stroke Yes No

Vascular Disease Yes No

Stomach Ulcer Yes No

High Cholesterol Yes No

Diabetes Yes No

Seizure Disorders Yes No

Do you use insulin? Yes No

Are you on medication? Yes No

Use an insulin pump? Yes No

Name of medication? \_\_\_\_\_

What age were you diagnosed? \_\_\_\_\_

Hepatitis A Yes No

Did you receive treatment? Yes No

Liver Biopsy? Yes No

Hepatitis B Yes No

Did you receive treatment? Yes No

Liver Biopsy? Yes No

Hepatitis C Yes No

Did you receive treatment? Yes No

Liver Biopsy? Yes No

Name of Doctor who treated your Hepatitis: \_\_\_\_\_ Tel#: (\_\_\_\_)\_\_\_\_\_

Have you had Cancer? Yes No If **Yes**, what type? \_\_\_\_\_

Date of Diagnosis? \_\_\_\_\_

Type of treatment? \_\_\_\_\_

Name of Doctor who treated your Cancer: \_\_\_\_\_ Tel#: (\_\_\_\_)\_\_\_\_\_

Blood Transfusions? Yes No If **Yes**, how many units? \_\_\_\_\_ Approximately when? \_\_\_\_\_

Are you willing to receive blood transfusions if needed? Yes No

Are you a smoker? Yes No If **No**, did you ever smoke? Yes No

If **Yes**, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? Yes No If **Yes**, how often? \_\_\_\_\_

Have you ever used recreational drugs? Yes No Are you currently using these? Yes No

Name(s) of recreational drugs used: \_\_\_\_\_

Do you take medication for anxiety or depression? Yes No

Name of Medication(s): \_\_\_\_\_

Are you currently under the care of a Psychiatrist or Psychologist? Yes No

Name of your Psychiatrist or Therapist: \_\_\_\_\_ Tel#: (\_\_\_\_)\_\_\_\_\_

**For Female Patients Only:**

Number of pregnancies: \_\_\_\_\_ Is it possible for you to become pregnant? Yes No

Are you using birth control? Yes No What type of birth control do you use? \_\_\_\_\_

Previous Surgeries/Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**KIDNEY DISEASE HISTORY:**

What caused your kidneys to fail? \_\_\_\_\_ Do you still make urine? Yes No  
Have you started dialysis? Yes No If **Yes**, when did you start? Date: \_\_\_\_\_  
Type of dialysis? Hemodialysis at a center Hemodialysis at home Peritoneal  
If on Hemodialysis: what is your schedule? Mon-Wed-Fri Tues-Thurs-Sat Nocturnal (overnight)  
what is your shift? 1st 2nd 3rd Nightly at home  
Have you ever had a kidney biopsy? Yes No

**Name of Dialysis Center:** \_\_\_\_\_ **Tel#:** (\_\_\_\_)\_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

**Have you had a kidney transplant?** Yes No If Yes, how many? \_\_\_\_\_  
**Transplant #1** Living Donor Deceased Donor Transplant Date: \_\_\_\_\_  
Name of Transplant Center: \_\_\_\_\_  
What side is the kidney on? Right Left Is it still in place? Yes No Failure Date: \_\_\_\_\_

**Transplant #2** Living Donor Deceased Donor Transplant Date: \_\_\_\_\_  
Name of Transplant Center: \_\_\_\_\_  
What side is the kidney on? Right Left Is it still in place? Yes No Failure Date: \_\_\_\_\_

**Have you had any other transplant?** Yes No What Type? \_\_\_\_\_  
Name of Transplant Center: \_\_\_\_\_ Date of Transplant: \_\_\_\_\_

Do you have a possible Living Donor? Yes No Do you still take Anti-Rejection medication? Yes No  
Are you currently listed with another transplant center? Yes No If **Yes**, which one: \_\_\_\_\_

**MEDICAL RECORD CHECKLIST: ◆YOU MUST SUBMIT ALL REQUIRED ITEMS LISTED BELOW◆**

- Recent Dictated (Typed) History and Physical from your Nephrologist
- Nephrologist Progress Notes
- Dialysis Progress Notes (**Required only if you are on dialysis**)
- Dialysis Social Worker Assessment (**Required only if you are on dialysis**)
- Recent Laboratory Results from you Nephrologist or Dialysis Center
- Copy of CMS 2728 Form (**Required only if you are on dialysis. Ask your Dialysis Center to give you a copy**)
- Legible copy of your Driver's License, Insurance card(s), and Drug Coverage card (**front and back**)
- Complete "Insurance Information" Form (**page 4**) and sign "Financial Agreement" Form (**page 5**)
- Pathology reports and medical records (**Required for all patients with a reported history of cancer**)
- Colonoscopy (**Required for all patients 50 years of age and above. We will accept if done within last 5 years**)
- Pap Smear (**Required for FEMALE patients 18 years of age and above. Results must be within last 12 months**)
- Mammogram (**Required for FEMALE patients 40 years of age and above. Results must be within last 12 months**)
- \*\*\*\* Cardiac Nuclear Stress Test (**Required for ALL DIABETICS & PATIENTS OVER 50 YEARS OLD. Must be within last 12 months**)
- \*\*\*\* Written Cardiac Clearance for transplant surgery from your Cardiologist (**Results must be within last 12 months**)
- \*\*\*\* If you have a cardiac pacemaker, please submit a copy of the Name, Model and Serial Number of the pacemaker

**I have completed the application and enclosed all necessary items on the above checklist. I understand that physical examinations, financial, psychosocial and dietary assessments along with diagnostic and laboratory testing will be included as part of my transplant evaluation. Laboratory testing will include: HIV and Drug Screenings.**

**PATIENT/LEGAL GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Name of person filling out form if not the patient:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**INSURANCE INFORMATION:**

**PLEASE COMPLETE ALL SECTIONS**

LEGAL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(First) (MI) (Last) (Maiden)

**MEDICARE INFORMATION**

Are you enrolled in **Medicare**? Yes No If **No**, are you eligible for **Medicare**? Yes No Unsure  
If **Yes**, what is your **Medicare Number**: \_\_\_\_\_

Is Your **Medicare** Coverage: Primary Secondary Third Pending **Part A Effective Date:** \_\_\_\_\_  
**Part B Effective Date:** \_\_\_\_\_

Are you on **Medicare** because of kidney disease? Yes No If **No**, is your coverage due to? Age Another disability

**MEDICAID INFORMATION**

Are you enrolled in **Medicaid**? Yes No If **Yes**, what is your **Medicaid Number**: \_\_\_\_\_

Is Your **Medicaid** Coverage: Primary Secondary Third Pending

Are you enrolled as "**Medically Needy**"? Yes No If **Yes**, what is your monthly **Share-of-Cost** Amount? \_\_\_\_\_

**OTHER INSURANCE** (This includes employer group plans, purchased supplemental plans, and COBRA plans)

Insurance Company Name: \_\_\_\_\_ Tel#: (\_\_\_\_) \_\_\_\_\_

Policy or Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Is this an employer group health plan? Yes No If **Yes**, Employer Name? \_\_\_\_\_

Are you the Policy holder? Yes No If **No**, Please answer the following:

Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Type? HMO PPO POS Indemnity Supplemental **Is this a COBRA Policy?** Yes No

Is this Coverage: Primary Secondary Third **Premiums are paid by?:** Self Employer American Kidney Fund

Insurance Company Name: \_\_\_\_\_ Tel#: (\_\_\_\_) \_\_\_\_\_

Policy or Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Is this an employer group health plan? Yes No If **Yes**, Employer Name? \_\_\_\_\_

Are you the Policy holder? Yes No If **No**, Please answer the following:

Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Type? HMO PPO POS Indemnity Supplemental **Is this a COBRA Policy?** Yes No

Is this Coverage: Primary Secondary Third **Premiums are paid by?:** Self Employer American Kidney Fund

**PRESCRIPTION DRUG COVERAGE**

I have prescription drug coverage through: Medicare Part D Medicaid Private Insurance Veterans Administrator

Member ID #: \_\_\_\_\_ Company Name: \_\_\_\_\_ Tel#: (\_\_\_\_) \_\_\_\_\_

If prescription drug coverage is through the V.A., what is the location? \_\_\_\_\_ Team: \_\_\_\_\_

**FINANCIAL AGREEMENT**

(Please read this carefully)

Organ transplantation is an expensive undertaking that will require a serious commitment on your part. It represents a partnership between you, your physicians, and the transplant team. Paying for the transplant and the on-going care and medications required after transplant are important factors that need to be considered if you choose transplantation as a treatment option. Therefore, it is important for you to understand the terms and conditions of your current health insurance coverage and to be aware of any changes that may affect this coverage. When you submit your transplant application, one of our Transplant Financial Coordinators will verify your health insurance coverage and determine if you have benefits to cover transplant services at Florida Hospital. If it is confirmed that you do have transplant benefit coverage, the Transplant Financial Coordinator will work on your behalf to obtain any necessary insurance authorizations required. Please be aware that it remains YOUR RESPONSIBILITY to notify the Transplant Financial Coordinator of ANY CHANGES TO YOUR HEALTH INSURANCE COVERAGE. If you make a change in insurance coverage you MUST send the Transplant Financial Coordinator a legible copy of your new health insurance card as soon as this change takes place. Failure to do so may jeopardize your ability to receive a kidney transplant at Florida Hospital.

If you elect to change coverage, it is important to ensure that you select an insurance company that will cover your transplant and related care, including medications, at Florida Hospital. Our Transplant Financial Coordinator can advise you on which insurance plans provide adequate coverage, as well as explain Medicare regulations as it pertains to End Stage Renal Disease. **We STRONGLY advise you to opt for Medicare Part B, as well as Part A once your Medicare eligibility begins.** Please be aware that if you have a potential living donor it will be *imperative* to have Medicare Part B as this will cover the medical charges incurred by your living donor. Ultimately, YOU are financially responsible for the medical services you receive. If your insurance company does not cover transplant services at Florida Hospital, or if there are co-pays and deductibles which are not covered by Medicare or your commercial health benefit plan, then you will be financially responsible for these payments. It is also *Extremely Important* that you maintain uninterrupted insurance coverage to ensure that your ongoing medical care and medications are covered.

If you have any questions or concerns regarding the financial aspect of your transplant care, please contact us at: **407-303-2474** and ask to speak to the Kidney Transplant Financial Coordinator.

**AGREEMENT:** Please read carefully and sign below

I understand that financial approval is based on my current health benefit insurance coverage and eligibility. If any changes occur related to this coverage, I agree to notify Florida Hospital Transplant Institute within one week of the change. My failure to do so can result in an insurance denial and/or my personal financial liability for any and all charges associated with my transplant medical care. My signature below authorizes Florida Hospital Transplant Institute to release information for purposes of obtaining financial approval for transplant services at Florida Hospital and Florida Hospital Transplant Institute. This may include physical assessments, mental health, substance abuse (e.g., drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. This may also include third party records received from you, or other healthcare providers sent on your behalf, to be used as part of your transplant evaluation.

**I understand and accept the terms of this financial agreement.**

\_\_\_\_\_  
 Print Patient Name or Legal Guardian

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Patient Signature or Legal Guardian

\_\_\_\_\_  
 Date

**Please check one of the following:**

- ONLY CONTACT ME TO DISCUSS ANY FINANCIAL ISSUES RELATED TO MY TRANSPLANT BENEFITS
- YOU MAY CONTACT THE FOLLOWING INDIVIDUAL TO DISCUSS ANY FINANCIAL ISSUES RELATED TO MY TRANSPLANT BENEFITS

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel#: \_\_\_\_\_