



**KIDNEY FOUNDATION**  
OF OHIO, INC.

## 2018 Emergency Insulin Program

### Overview

Approved applicants can receive an emergency supply of insulin, syringes, or pen needles. The grant is available **one time only**, and when no other assistance is available. The applicant will be notified by phone of approval or denial of the request. Approved individuals will receive supplies from one of two authorized pharmacies.

### Guidelines

- Incomplete applications will **NOT** be accepted or returned to the applicant.
- Program is limited to **Cuyahoga County** residents.
- The Kidney Foundation of Ohio's ability to assist individuals is based on the availability of funds. Therefore, an application for assistance is not a guarantee of acceptance or 'entitlement' to services.
- The U.S. Federal Poverty Guidelines will be used to determine the applicant's level of eligibility.
- Intentionally misleading information on the application is cause for denial of assistance.
- Program may be changed or discontinued at any time without notice.

#### **Return completed application to:**

Kidney Foundation of Ohio, Inc.  
2831 Prospect Avenue  
Cleveland, Ohio 44115  
(216) 771-5114 *fax*

#### **For Questions Contact:**

Molly DeBrosse, LSW  
(216) 771-2700  
[mdebrosse@kfohio.org](mailto:mdebrosse@kfohio.org)  
[www.kfohio.org](http://www.kfohio.org)

**Do Not Submit This Sheet with Application**

# 2018 Kidney Foundation of Ohio Emergency Insulin Application Cover Page

## Complete File Check List

Review and complete before sending application.  
Incomplete or illegible applications will not be processed.

- Pages 3 through 9 entirely complete
- Client release of information signed
- Emergency/one-time need
- All written content is legible

# 2018 Emergency Insulin Application

## Applicant Information

Date \_\_\_\_\_

**Applicant Name** \_\_\_\_\_

*If a minor, name of parent or guardian* \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Gender** (*circle one*) **Male** **Female**

**County** \_\_\_\_\_

### **Ethnic Origin:**

African American \_\_\_\_\_  
Asian/Pacific Islander \_\_\_\_\_  
Caucasian \_\_\_\_\_  
Latin American \_\_\_\_\_  
Native American \_\_\_\_\_  
Other \_\_\_\_\_

### **Diagnosis:** (*check all that apply*)

DM Type 1 \_\_\_\_\_  
DM Type 2 \_\_\_\_\_  
DM with Chronic Kidney Disease \_\_\_\_\_  
Diabetic Nephropathy \_\_\_\_\_  
Gestational DM \_\_\_\_\_  
Other (*explain*) \_\_\_\_\_

### **Prescription Information**

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ units per day Allergies: \_\_\_\_\_

Are you requesting syringes and/or pen needles? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how many per day: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Transferring Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Prescription Number: (*if available*) \_\_\_\_\_

**Date Last Shipment of Insulin Received** \_\_\_\_\_ (month/year)

**Coverage Information**

**Are you uninsured?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Do you have Medicaid?** \_\_\_\_\_ Yes \_\_\_\_\_ No

ID Number \_\_\_\_\_

**Do you have Medicare?** \_\_\_\_\_ Yes \_\_\_\_\_ No

ID Number \_\_\_\_\_

**Do you have Medicare Part D?** \_\_\_\_\_ Yes \_\_\_\_\_ No

Plan Name \_\_\_\_\_

Plan Number \_\_\_\_\_

**Do you have private or secondary insurance?** \_\_\_\_\_ Yes \_\_\_\_\_ No

Plan Name \_\_\_\_\_

Plan Number \_\_\_\_\_

**Are you a Veteran?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Do Not Write in Box - Kidney Foundation of Ohio Use Only**

Date _____	Bill Account # _____
<input type="checkbox"/> Approve <input type="checkbox"/> Deny	Patient Services Signature _____
Estimated Amount _____	Amount Approved _____
Notes: _____	
_____	

# Financial Information

To be completed by applicant or guardian  
All household member income must be completed

**Presently Employed?**    Yes    No

**How many people live in household?** \_\_\_\_\_

Please state additional household member's relationships (i.e., spouse, adult child, minor child, significant other)

\_\_\_\_\_

## Monthly Household Income

	Salary	SSI/SSDI	Pension	Child Support	TANF Includes Ohio Works First Program	Food Assistance Programs	Disability Assistance	Family Emergency Assistance	Other Assistance
<b>Applicant</b>									
<b>Spouse</b>									
<b>Child</b>									
<b>Other</b>									
<b>Total</b>									

**Total Monthly Income**                      \$ \_\_\_\_\_

**Monthly Household Expenses**

<b>Item</b>	<b>Amount</b>
<b>Medication</b> <i>(Out of Pocket)</i>	\$
<b>Rent/Mortgage</b>	\$
<b>Utilities</b>	\$
<b>Groceries</b>	\$
<b>Transportation</b>	\$
<b>Insurance</b>	\$
<b>Car Payment</b>	\$
<b>Entertainment</b>	\$
<b>Telephone</b> <i>(Include cell phone)</i>	\$
<b>Tuition/Education</b>	\$
<b>Loan Payments</b> <i>(Payment Per Month)</i>	\$
<b>Credit Card</b> <i>(Payment Per Month)</i>	\$
<b>Doctor</b> <i>(Payment Per Month)</i>	\$
<b>Medicare Part B</b>	\$
<b>Other Medical</b> <i>(Payment Per Month)</i>	\$
<b>Other Expenses</b>	\$

**Total Monthly Expenses**                      \$ \_\_\_\_\_

**Do Not Write in Box - Kidney Foundation of Ohio Use Only**

Monthly Income _____	Annual Income _____	Monthly Expenses _____
Poverty Level <100%	100%	133%
	150%	200%
	250%	>250%

# Assessment

To be completed by social worker, nurse or physician.

## Referring Medical Professional

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact E-Mail: \_\_\_\_\_

Please tell us the circumstances behind the applicant's request. Funding is allocated to individuals who demonstrate the most need. **Provide as many details as possible.**

## Program Need *(check all that apply)*

New Diagnosis \_\_\_\_\_

Job Loss \_\_\_\_\_

Loss of Insurance Coverage \_\_\_\_\_

Unable to Afford Medication \_\_\_\_\_

Unable to Afford Copay \_\_\_\_\_

Additional Details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Professional Signature \_\_\_\_\_

Date \_\_\_\_\_

## General Release of Information

My signature will authorize the Kidney Foundation of Ohio to communicate with the referring medical professional and their parent organization regarding the financial and social information contained in this application for patient assistance. My signature will also authorize the Kidney Foundation of Ohio to speak with the provider of services for which funds have been requested. The Kidney Foundation of Ohio and its affiliate Chapters do not re-grant to organizations, individuals, programs and/or projects outside of the United States of America.

## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until the Foundation replaces it. We reserve the right to change our privacy practices and applicable law permits terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

### **USES AND DISCLOSURE OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, it is good for 12 months or until the date you put on our forms, you may revoke it at any time. Your revocation will not affect any use of or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without written authorization.

**As Permitted or Required by Law:** Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities or to law enforcement officials, such as to comply with a court order or subpoena.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence, and other national security activities to authorized federal officials. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment of Program Reminders:** We may disclose your health information to provide you with reminders or notices (such as voicemail messages, e-mail, postcards or letters).

### **CLIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a photocopy format. We will use this format unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for copies of your health information. You may also request access by sending a letter to the address at the end of this Notice. We will respond to your request within 30 days of receipt to either give you rights to access or a written explanation of denial of your request.

If you request a copy of your records, we will charge you .50 cents for each page not to exceed a total charge of \$15.00 to photocopy your health records or other requested forms. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using this information listed at the end of this Notice for a full explanation of our fee structures.



**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional charges.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by your agreement (unless otherwise specified by law or other restrictions listed in this Notice.)

**Alternate Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative location. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation on how payments will be handled under the alternative means or location request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances. If we did not create the information, we will refer you to the sources, such as your dialysis center, physician or hospital.

**Electronic Notice:** If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## Questions or Complaints

If you would like more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means, or at alternative locations, you may complain to us using contact information listed at the end of this Notice.

**Contact Officer:**     **Molly DeBrosse**  
                                  **Telephone: (216) 771-2700**  
                                  **Address: 2831 Prospect Avenue, Cleveland, Ohio 44115**

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_