KIDNEY FOUNDATION
OF OHIO, INC.

2018 Medication Assistance Program

Overview

This program is based on the amount of funding available and is limited to the Foundation's thirty-seven county service area (visit www.kfohio.org for list of counties). The program provides financial aid to help individuals purchase renal medications and nutritional supplements. Approved program participants receive $200 during each 6 month period (up to $400/year) to purchase medications through an approved pharmacy. If approved, **renewals must be submitted by July 1st** to maintain funding on program. Priority is given to people who are uninsured or underinsured.

The above amount will differ for Lake and Summit County patients.

Guidelines

- Incomplete applications will **NOT** be accepted or returned to the patient or social worker.
- Applications one month or more out of date will **NOT** be accepted or returned to the patient or social worker.
- Application must be from current year. Old applications will **NOT** be accepted.
- Medication assistance cannot be awarded in conjunction with transportation assistance.
- Patient assistance application **must be completed annually** without exception.
- The Kidney Foundation of Ohio's ability to assist patients 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 patient's level of eligibility. Intentionally misleading information on the application is cause for denial of assistance.
- There is a minimum two-week review process for all applications.
- Programs 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
www.kfohio.org

Do Not Submit This Sheet with Application

2018 Medication Assistance Application Cover Page

Complete File Check List

Review and complete before sending application, incomplete or illegible applications cannot be processed.

- □ Medication list attached
- □ Pages 3 through 9 entirely complete
- □ Client Release of Information signed by client
- □ Dated within one month of fax date
- □ If requesting nutritional supplement, additional form must be attached
- □ All written content is legible

Kidney Foundation of Ohio Use Only

Please continue to next page

Interaction Notes:

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

2018 Medication Assistance Application
Patient Information

Date _____

Patient Name_____

*If a minor, name of parent or guardian*_____

Date of Birth_____ **Age**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Phone _____ **Gender** *(circle one)* **Male** **Female**

Ethnic Origin: for reporting purposes only

African American _____
Asian/Pacific Islander _____
Caucasian _____
Latin American _____
Native American _____
Other _____

Requesting Nutritional Supplement?

☐ **Yes** ☐ **No**

County of Residence_____

Summit County Only: *CIRCLE*

Preferred Pharmacy: ExactCare or Ritzman

Diagnosis: *(check all that apply)*

_____ End Stage Renal Disease
_____ Nephrosis or Nephrotic Syndrome
_____ Chronic Glomerulonephritis
_____ Chronic Pyelonephritis
_____ Polycystic Kidney Disease
_____ Diabetic Nephropathy
_____ Other _____

Mode of Treatment: *(check all that apply)*

_____ Pre-dialysis
_____ Home Hemodialysis
_____ Hemodialysis
_____ Peritoneal Dialysis
_____ Awaiting Transplant
_____ Transplant
_____ Other _____

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☐ **Approve** ☐ **Deny** ☐ **Waitlist**

Date: _____ **Bill Account** _____

Monthly Income: $_____ **Monthly Expenses:** $_____ **Annual Income:** $_____

Insurance: ☐Medicaid ☐Medicare ☐Medicare Part D ☐Other:_____

Poverty Level: ☐< 100% ☐100% ☐133% ☐150% ☐200% ☐250% ☐>250%

***Patient Services Signature*:**_____

Social Worker_____

Physician_____

Dialysis Unit/Transplant Hospital_____

Address_____

City, State, Zip_____ **County**_____

Unit Phone _____ **Unit Fax** _____

Contact E-Mail_____

Financial Information

To be completed by patient or guardian

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 (Ex: AKF, Pharmaceutical Patient Assist Programs)
Applicant									
Spouse									
Child									
Other									
Total									

Total Monthly Income **$**_____

Monthly Household Expenses

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

Total Monthly Expenses **$_____**

Coverage Information

Are you on Medicaid? ☐ Yes ☐ No

Are you covered by Medicare? ☐ Yes ☐ No

Are you covered by Medicare Part D? ☐ Yes ☐ No

If yes, list plan name & number_____

Are you enrolled in LIS (Limited Income Subsidy)? ☐ Yes ☐ No

Do you have private or secondary insurance? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Are you uninsured? ☐ Yes ☐ No

Assessment

To be completed by social worker, nephrologist or urologist

Please complete a professional assessment. **Provide as many details as possible.** Funding is allocated to individuals who demonstrate the most need. Please tell us the circumstances behind the applicant's request. Please see the examples provided below:

Acceptable: Client is unable to work due to dialysis treatments, and is requesting this assistance as the copay for his/her medication is a burden to them. The client has been unable to purchase necessary medications for 3 months.

Unacceptable: Client is applying for assistance due to financial hardship.

Print clearly **–** illegible professional assessments may hinder the evaluation process.

Professional Assessment:

Social Worker/Physician Signature _____

Date _____

Medication Assistance

If provided assistance, how would you apply the funds? **Check all that apply**:

- ☐ Medication(s) not covered by insurance
- ☐ Nutritional supplements **(if requesting nutritional supplements, form MUST be filled out)**
- ☐ Copay/deductible assistance
- ☐ Over the counter prescriptions

Additional Data

To be completed by social worker, nephrologist or urologist
Information provided to be utilized solely for program evaluation purposes

Did patient receive funding from Kidney Foundation of Ohio's Medication Assistance Program in 2017?

☐ Yes ☐ No

Number of medications patient takes on a daily basis: _____

Is the patient able to afford all prescribed medications or nutritional supplements? ☐ Yes ☐ No

Patient needs help paying for how many medications? _____

Length of time on dialysis. Please specify **years** or **months**. _____

THIS INFORMATION IS **REQUIRED** IN ORDER FOR APPLICATION TO BE PROCESSED.

Please attach current medication list,

include both prescription and over the counter medications.

General Release of Information

My signature will authorize the Kidney Foundation of Ohio to communicate with the dialysis center and/or transplant center social worker/staff 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 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 it 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, LSW**
Telephone: (216) 771-2700
Address: 2831 Prospect Avenue, Cleveland, Ohio 44115

Patient Signature _____ **Date**_____