KIDNEY FOUNDATION
OF OHIO, INC.

2022 Emergency Insulin Program

Overview

Approved applicants can receive an emergency supply of insulin, syringes, or pen needles. The program 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 and returned to the patient or social worker.
- Program is limited to **Cuyahoga County** residents.
- The Kidney Foundation of Ohio's ability to assist individuals is based on the availability of funds. An application for assistance is not a guarantee of acceptance or "entitlement" to services.
- 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.
- 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
programs@kfohio.org
(216) 771-5114 *fax*

For Questions Contact: Molly DeBrosse, LSW
programs@kfohio.org
(216) 771-2700
www.kfohio.org

Do Not Submit This Sheet with Application

Kidney Foundation of Ohio
2022 Emergency Insulin Application

Applicant Name____ **Date**________________

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

Date of Birth_____/______/_____ **Age**____ **Gender** ____Male ____Female ____ Non Binary

Address____

City______________________________ **State**__________ **Zip Code**__________________

Phone____________________________ **County of Residence**________________________

Social Security Number____

Email ____

Diagnosis: *(check all that apply)*

____DM Type 1

____DM Type 2

____DM with Chronic Kidney Disease

____Diabetic Nephropathy

____Gestational DM

____Other *Diagnosis:* ________________________

Ethnic Origin:

____African American

____Asian/Pacific Islander

____Caucasian

____Latin American

____Native American

____Other *List:* ____________________________

Prescription Information

Name of Medication: _______________________________________ Type: _____Vial _____Pen

Dosage: __________ units per day Allergies: ____

Requesting syringes and/or pen needles? _____Yes ______No If so, how many per day: _________

Additional Notes: ____

Prescribing Physician: ______________________________ Phone: ____________________________

Health System Affiliation: __CDC __Cleveland Clinic __DaVita __Fresenius __MetroHealth __University Hospitals Other: __________

Transferring Pharmacy: ______________________________ Phone: ____________________________

Prescription Number if Available: ____

Date Last Shipment of Insulin Received: Month__________________ Year___________________

Coverage Information

Are you on Medicaid? ____Yes ____No

ID Number____

Are you covered by Medicare? ____Yes ____No

ID Number____

Are you covered by 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

Are you uninsured? ____Yes ____No

Who referred you to the program? ____

Do not complete box below

_____Approve **_____Deny**

Date ____________________________ **Bill Account**____

Estimate $________________________ **Amount Approved** $___________________________________

Patient Services Signature____

Notes: ____

Financial Information

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

Presently Employed? ____Yes ____No **Household Members** ____Self ____Spouse ____Dependents

List all dependents living in household: ____
**Make sure to list all adults, children, grandchildren, etc.*

Monthly Household Income

Please list income from all household members below.

	Salary	*SSI/SSDI*	*Pension*	*Child Support*	*TANF (include Ohio Works First Program)*	*Food Assistance Program*	*Child Tax Rebate/Tax Credits*	*Unemployment Compensation*	*Other Assistance (examples are AKF, Pharmaceutical Assistance Programs)*
Applicant									
Spouse									
Child #1									
Child #2									
Other									
Total									

Total combined monthly income from all sources listed above $___________________________________

Annual income (Number listed above x 12) $___________________________________

Monthly Expenses

Item	Monthly Payment Amount
Medication (Out of pocket cost only)	$
Rent/Mortgage	$
Utilities (Combined Average)	$
Groceries	$
Transportation (Bus Fare, Gas, Taxi, Uber/Lyft)	$
Insurance	$
Car Payment	$
Entertainment	$
Telephone (Include Cell Phone)	$
Tuition/Education (Include Student Loans)	$
Other Loan Payments (List Type) ____	$
Credit Card Payments (Total per month)	$
Doctor/Hospital (Copays, Deductibles, Monthly out of pocket cost only)	$
Medicare (Premiums, Part B, Supplemental)	$
Other Medical Expenses (List Type) _____________________________________	$
Other Expenses (List Type) ____	$

Total monthly expenses from all sources listed above $____

Do not complete box below

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's Name: ____

Organization: ____

Address: ____

City: ____________________________________ **State:** _____________ **Zip Code:** ___________________________

Phone: ___________________________________ **Unit Fax:** ____

Email: ____

Professional Assessment: Tell us the circumstances behind the applicant's request. Funding is allocated to individuals that demonstrate the most need. Provide as many details as possible. (W*rite in space below)*

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Program Need: (*check all that apply)*

_____New Diagnosis _____Loss of Insurance Coverage _____Job Loss

_____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 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 or undocumented citizens. The Organization does not and will not provide financial or material support or resources to any entity that has knowingly concealed the source of funds used to carry out terrorism or to support Foreign Terrorist Organizations.

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 January 1, 2016. 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/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, please call or send written notice to the Contact Officer below:

Contact Officer: Molly DeBrosse, LSW

Telephone: (216) 771-2700

Address: 2831 Prospect Avenue, Cleveland, Ohio 44115

Patient Signature ___________________________________ **Date**____________________