KIDNEY FOUNDATION OF LAKE COUNTY

an affiliate of the Kidney Foundation of Ohio, Inc.
Phone: (440) 413-3566

General Information

The Kidney Foundation of Lake County is a not-for-profit organization that provides temporary aid to patients impacted by kidney disease and transplant patients who need financial help. The program provides financial aid to help individuals purchase renal medications or nutritional supplements through an approved pharmacy. If approved, a **renewal form must be submitted by January 31st** to maintain funding on program. Priority is given to people who are uninsured or underinsured.

Guidelines

- Incomplete applications will **NOT** be accepted and will be returned to the social worker.
- Applications one month or more out of date will **NOT** be accepted and returned to the social worker.
- Application must be from current year. Old applications will **NOT** be accepted.
- Patient assistance application **must be completed annually** without exception.
- The Kidney Foundation of Lake County'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.

Individual Program Overview

Medication Assistance: Priority will be given to patients who have no other form of assistance such as Medicaid, Medicare or private insurance. Patients will receive a grant to purchase medications through an approved Kidney Foundation of Ohio pharmacy, based on funding.

Transportation Assistance: Mileage Reimbursement is available for dialysis, nephrology appointments or transplant work-ups. Priority will be given to long distance patients. The average reimbursement is based on funding. Patients will receive 2 checks, one in September 2024 and the other in April 2025.

Emergency Grants: Emergency grants are available one-time per year, based on funding. Grant payments are made to third party providers, not to the patient. **Attach the ENTIRE copy of ONE bill for which assistance is requested to this application**. The Foundation does not pay for the following: long-distance phone calls, entertainment numbers, or non-essential phone charges, bills already paid, loans, rent, lease, mortgage, real estate costs or credit cards.

Return completed application to your healthcare provider.

Healthcare Provider: Review, sign, and return to **programs@kfohio.org**
or fax to (216) 771-5114

For Questions:
Contact Jennifer Clegg, LISW-SUPV
(216) 771-2700
programs@kfohio.org
To submit the application online, visit www.kfohio.org

Do Not Submit This Sheet with Application

Kidney Foundation of Lake County
2024-2025 Patient Assistance Application

PLEASE PRINT IN BLUE OR BLACK INK

Patient 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 Number (_____) _____ **Email** _____

County of Residence _____ **Are you a US Citizen?** ☐Yes ☐No

Requesting Nutritional Supplements ☐Yes ☐No

First date of dialysis or date of transplant _____

For reporting purposes only

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐Black or African American

☐Native Hawaiian or other Pacific Islander ☐White/Caucasian ☐Other

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Diagnosis: *(check all that apply)*

☐ End Stage Renal Disease

☐ Nephrosis or Nephrotic Syndrome

☐ Chronic Glomerulonephritis

☐ Polycystic Kidney Disease

☐ Diabetic Nephropathy

☐ Other *Diagnosis:* _____

Would patient like to receive a **free** ID band?

Circle access location:

ARM ABDOMEN CHEST LEG NECK TRANSPLANT

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

☐Pre-Dialysis

☐Home Hemodialysis

☐Hemodialysis

☐Peritoneal Dialysis

☐Awaiting Transplant

☐ Post Transplant - Transplant Date: _____

☐Other _____

DO NOT COMPLETE BOX BELOW

Date _____ Monthly Income $_____ Expenses $_____ Annual Income $_____

Medication Assistance (6055)	☐ Approve	☐Deny	$_____ Total
Transportation Assistance (6056)	☐Approve	☐Deny	$_____ Total
Emergency Assistance	☐Approve	☐Deny	$_____ One-time payment

Poverty Level <100% 100% 125% 150% 175% 200% 250% >250%

KFO Signature_____

KFO Lake County Approval Yes No Date: _____

Health Care Worker_____**Discipline**_____

Dialysis Unit/Transplant Unit_____

Unit Address_____

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

Unit Phone_____ **Unit Fax**_____

Health Care Worker's Email_____

Physician_____

Financial Information

To be completed by patient or guardian

Presently Employed? ☐Yes ☐ No **Household Members** ☐Self ☐Spouse ☐Dependents

List all dependents living in household (adults, children, grandchildren, etc.) and ages:

_____

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, SNAP***	***Unemployment Compensation/ Workman's Compensation***	***Short Term or Long term disability from employer***
Applicant	$	$	$	$	$	$	$	$
Spouse	$	$	$	$	$	$	$	$
Child #1	$	$	$	$	$	$	$	$
Child #2	$	$	$	$	$	$	$	$
Other	$	$	$	$	$	$	$	$
Total	$	$	$	$	$	$	$	$

Total combined monthly income from all sources listed above **$**_____

Annual income (Number listed above x 12) **$**_____

Total monthly income from all sources not listed above **$**_____

If monthly income is left bank, please specify why: _____

_____

Monthly Expenses

Item	Monthly Payment Amount
Medication (Out of pocket cost only)	$
Rent/Mortgage	$
Utilities (Combined Monthly Average)	$
Groceries	$
Transportation (Bus Fare, Gas, Taxi, Uber/Lyft)	$
Insurance (car, home, life)	$
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, Part D, Supplemental) *Not deducted from SSA*	$
Other Medical Expenses (List Type) _____	$
Other Expenses (List Type) _____	$

Total monthly expenses from all sources listed above $_____

Coverage Information

Are you covered by Medicaid? ☐Yes ☐No

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

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

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

Are you uninsured? ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

If insured, does your insurance cover transportation? ☐Yes ☐No

Attestation of Need

To be completed by social worker, nephrologist, urologist, or nurse

The Kidney Foundation depends on your honest and accurate assessment of the patient's financial need. ***If this application is submitted for an Emergency Grant request, please include in your statement the plan of action to prevent future issues.***

Please complete a professional attestation of need.
Provide as many details as possible. Funding is allocated to individuals who demonstrate the most need. Include the circumstances behind the applicant's request. See examples below:

Acceptable: Client is unable to work due to dialysis treatments. They are requesting assistance because their copays for medication is a burden to them. The client has been unable to purchase necessary medications for 3 months. ***DO NOT USE THIS EXAMPLE.***

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

Professional Attestation of Need:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Social Worker/Medical Professional Signature **Date**

Medication Assistance Program

Applying for Medication Assistance? ☐ Yes ☐ No

Did patient receive funding from the Medication Assistance Program in 2023/2024? ☐ 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? _____

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, additional form MUST be filled out)**
- ☐ Copay/deductible assistance
- ☐ Over the counter prescriptions

Transportation Assistance Program

Applying for Mileage Assistance? ☐ Yes ☐ No

Does patient have at least one standing appointment related to Kidney Disease? (i.e. Dialysis, transplant work-ups, etc.)
☐ Yes ☐ No Type of appointment: _____

Primary source of transportation for dialysis/transplant appointments.
☐ Auto ☐ Public Transportation ☐Medicaid/ NET ☐ Uber/Lyft/Taxi ☐ Other _____

Did patient receive transportation assistance from the Kidney Foundation of Ohio in 2023/2024? ☐ Yes ☐ No
# of appointments relating to kidney disease patient is currently SCHEDULED for per month _____
# of appointments relating to kidney disease ACTUALLY attended last month _____
# of miles to dialysis treatment or transplant appointment (ONE WAY) _____

Please note applications received after August 1st will not receive a check until March 2025. Application received after March 1st will not be processed and patients will need to reapply in July.

Emergency Grant Program

Applying for Emergency Grant? ☐ Yes ☐ No

Purpose for emergency assistance: _____

Amount Requested $_____ ***(Copy of full bill required; max grant amount is $200)***

Did patient receive emergency assistance in 2023/2024? ☐ Yes ☐ No

Has patient had a previous disconnection notice in the past 12 months? ☐ Yes ☐ No

If requesting energy assistance, is patient enrolled in HEAP (Home Energy Assistance Program? ☐ Yes ☐ No

Does patient have a plan in place to avoid future issues with this expense? ☐ Yes ☐ No

Please provide additional details about patient's plan to avoid future issues with this expense:

_____

General Release of Information

My signature will authorize the Kidney Foundation of Ohio to communicate with the pharmacy staff, dialysis center, medical provider's office, hospital 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

The Kidney Foundation of Ohio will store provided information in an electronic health record which is secured, and access is limited to the Program staff at the Kidney Foundation of Ohio and their Affiliate Chapters. Your personal information will not be sold to any entity. Demographic information including age, race, gender, poverty guidelines and location may be provided to funding sources, but identifying information will not be released to protect your privacy. If you are applying for Medication Assistance, your information, which includes name, address, phone number and date of birth, will be shared with the contracted pharmacy to fulfill prescription and/or nutritional supplement orders. You can discontinue your involvement in the direct assistance program at any time by contacting the Kidney Foundation of Ohio. All applications submitted will be retained in a locked file for a minimum of seven years.

Questions or Complaints

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.

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

Contact:
Preston D. Moss, President
Kidney Foundation of Lake County
Phone: (440) 413-3566
cpmoss@att.net

Patient Signature _____ **Date**_____