KIDNEY FOUNDATION OF OHIO, INC.

2024 Emergency Assistance Program

Overview

The Emergency Assistance 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). A $100 emergency grant, available once per calendar year, is issued when no other assistance is available. Unexpected high utility bills, auto repairs, and medical supplies are often situations where emergency grants are awarded.

Attach ONE CURRENT bill; a copy of the ENTIRE bill is required. The Foundation does **NOT** pay for the following: phone or cable TV charges, bills already paid, loans, rent, lease, mortgage, moving expenses, furniture or credit card payments.

Guidelines

- **Bills over $1,000 will not be considered.**
- Incomplete applications will **NOT** be accepted and will be returned.
- Applications one or more months out of date will **NOT** be accepted and will be returned.
- Checks are mailed **directly to third party providers**, not the patient or healthcare professional.
- A **shut-off notice** is required for utility bills.
- The Kidney Foundation of Ohio's ability to assist patients 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.
- 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 your healthcare provider.

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

For Questions:
(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 Ohio
2024 Emergency Assistance Application

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_____ **County of Residence**_____

Email_____

Ethnic Origin: *for reporting purposes only* ____ American Indian ____Asian/Pacific Islander

____Black or African American ____Latin American ____White/Caucasian ____Other

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

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

____Pre-Dialysis

____Home Hemodialysis

____Hemodialysis

____Peritoneal Dialysis

____Awaiting Transplant

____Transplant

____Other *Mode:* _____

DO NOT COMPLETE BOX BELOW

_____**Approve** _____**Deny** **Reason**_____

Date _____ **Bill Account**_____

Monthly Income $_____ **Monthly Expenses** $_____ **Annual Income** $_____ **$ Available**_____

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

Emergency One-Time Need Yes No **Bill Under $1,000** Yes No

Shut-Off Notice Yes No **Payment Plan** Yes No

KFO Signature_____

Social Worker_____

Dialysis Unit/Transplant Unit_____

Unit Address_____

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

Unit Phone_____ **Unit Fax**_____

Social 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, child, 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*	*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 **$**_____

Coverage Information

Are you on 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)? ☐ 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, urologist, or nurse

Please complete a professional assessment.

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 and has limited income. Due to unexpected medical expenses from recent hospital stay, client became behind on utility bill. Client will contact utility company to apply for energy assistance program and make monthly payments to reduce balance. ***DO NOT COPY THIS EXAMPLE.***

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

Professional Assessment:

Social Worker/Medical Professional Signature

Date

Required Additional Data

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

Emergency Assistance:

Did patient receive funding from the Kidney Foundation of Ohio's Emergency Assistance Program in 2023?

☐ Yes ☐ No

Does the bill include a shut-off notice? *(Utility bills that are <u>not</u> shut-off notices will be denied.)*

☐ Yes ☐ No

Is the bill being submitted under the $1,000 threshold for consideration? *(Bills <u>over</u> $1,000 will be denied.)*

☐ Yes ☐ No

If home energy assistance is requested, has patient enrolled in HEAP (Home Energy Assistance Program)?

☐ Yes ☐ No

Does the patient have a plan in place to avoid future issues with this expense?

☐ Yes ☐ No

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

_____

_____

What was the patient's dialysis start date? _____ (MM/DD/YYYY)

Requirement: Copy of Disconnection Notice

A current copy of the bill is required to be <u>ATTACHED</u> to application

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, 2018. 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. It is the responsibility of the patient to notify the Kidney Foundation of Ohio of changes to their home address or phone number. If the assistance rendered is inaccessible due to inaccurate contact information, the assistance will not be re-issued.

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: **Jennifer Clegg, MSW, LISW-SUPV**
Telephone: (216) 771-2700
Address: 2831 Prospect Avenue, Cleveland, Ohio 44115

Patient Signature _____ **Date**_____