Kidney Foundation of Summit County

A Kidney Foundation of Ohio Affiliate Chapter

2025 Nutrition Supplement Grant Program

Overview

- The program provides financial aid to help individuals purchase nutritional supplements through an approved provider, Mobile Meals, Inc.
- The social worker/dietitian must complete the application with the patient. The patient must sign the privacy practices page and release of information to allow the Kidney Foundation of Summit County to coordinate delivery of service with Mobile Meals, Inc.
- The Kidney Foundation of Summit County will review application and notify social worker/dietitian of the status of the application via email.
- Applications are considered on an individual basis. Special consideration is given to those patients who are 300% or below of the Federal Poverty Level.
- **The grant allots $65.00 per month towards purchase of nutritional supplements.** *Example: patient is approved for the grant beginning in August and lasting through December, $325 will be set aside by the Foundation for the supplement.* Funds may be used until depleted. Additional funds will not be authorized once full approved amount has been utilized.
- **If approved, the social worker/dietitian will fax the Mobile Meals referral form and letter of grant approval to Mobile Meals to initiate services.**
- Only the supplements currently available through Mobile Meals, Inc. are part of the grant program.
- The Kidney Foundation of Summit County's ability to assist patients is based on the availability of funds based on donations and will be looked at on an individual basis. An application for assistance is not a guarantee of acceptance or "entitlement" to services. If funding is not available, the social worker and dietitian will be given a thirty-day (30) notice to alert the patient.
- **The grant expires December 31, 2025.**
- A new patient assistance application **must be completed annually** without exception.
- Intentionally misleading information on the application, or misuse/selling of supplements is cause for denial of assistance.

Return completed application to:

Kidney Foundation of Summit County
567 Dellcastle Ct. NW
Calabash, NC 28467

For Questions Contact:

Carolyn Henretta, Executive Director
Carolynruns@yahoo.com
Phone: 330-864-1236

Kidney Foundation of Summit County

2025 Nutrition Supplement Grant Program 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:* _____

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

☐ Pre-Dialysis
☐ Home Hemodialysis
☐ Hemodialysis
☐ Peritoneal Dialysis
☐ Awaiting Transplant
☐ Transplant
☐ Other *Mode:* _____

Financial Information

Household Income from all sources: _____

Number of people residing in the household: _____

Had the patient received assistance in 2024? _____

Describe if other assistance has been utilized to obtain nutrition supplements:

_____

_____

Is there potential for future eligibility for above mentioned programs?

_____

Healthcare Professional Contact Information

Social Worker:_____

Dialysis Unit/Transplant Unit_____

Unit Address_____

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

Unit Phone_____ **Unit Fax**_____

Social Worker's Email_____

Dietitian: _____

Dialysis Unit/Transplant Unit_____

Unit Address_____

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

Unit Phone_____ **Unit Fax**_____

Dietitian's Email_____

General Release of Information

My signature will authorize the Kidney Foundation of Summit County to communicate with the dialysis center and/or transplant center staff regarding the financial and social information contained in this application for patient assistance. My signature will also authorize the Kidney Foundation of Summit County to speak and coordinate with the provider of services (Mobile Meals, Inc.) for which funds have been requested. Mobile Meals, Inc. will be providing the supplement. Literature regarding Mobile Meals, Inc. additional services may be included with the delivery. You are not obligated to take advantage of any of these additional programs or services. Should the Kidney Foundation of Summit County need to change the nutrition supplement provider, you will be asked to sign a new release of information to indicate permission to change providers.

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.

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: Carolyn Henretta
Telephone: 330-807-1083
Address: 567 Dellcastle Ct. NW., Calabash NC 28467

Patient Signature: _____

Date: _____

Social Worker Signature: _____

Date: _____

Dietitian Signature: _____

Date: _____