

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 Kidney Foundation's patient assistance application consists of (*check all that applies to the patient's application*):

Application Checklist

	Patient Information & Assessment (<i>required</i>)
	Medication assistance questions and medication list (<i>if applying</i>)
	Transportation assistance questions (<i>if applying</i>)
	Emergency grant questions (<i>if applying, include copy of bill</i>)
	Signed General Release of Information (<i>required</i>)

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- Applications one month or more out of date will **NOT** be accepted and returned to the social worker.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.

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.

Kidney Foundation of Lake County 2022-2023 Patient Assistance Application

Complete all required information. Incomplete applications will not be processed.

Select all that apply. Valid only for grants 7/1/2022-6/30/2023.

Type of Assistance Requesting Medication Transportation Emergency

Date _____

Patient Name _____

Address _____ City, State, Zip _____

Daytime Phone () _____ Evening Phone () _____

Date of Birth _____ Age _____ Gender (circle one) Male Female

County of Residence _____

If a minor, name of parent or guardian _____

Social Worker _____

Social Worker's email _____

Physician _____

Dialysis Unit/Transplant Hospital _____

Address _____ City, State, Zip _____

County _____

Unit Phone () _____

Unit Fax () _____

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
- _____ Hemodialysis
- _____ Peritoneal Dialysis
- _____ Awaiting Transplant
- _____ Transplant
- _____ Other _____

<u>Ethnic Origin</u>	
African American	_____
Caucasian	_____
Latin American	_____
Native American	_____
Other	_____
Decline to answer	_____

Financial Information

Presently Employed? Yes No

Number of Household Members: Self _____ Spouse _____ Dependents _____

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	Child Tax/Tax Rebate	Other Assistance (Ex: AKF, Pharmaceutical Patient Assist Programs)
Applicant									
Spouse									
Child									
Other									
Total									

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

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

Monthly Household Expenses

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

Application will not be accepted without completion by the patient's **social worker, nephrologist or urologist.**

**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
assessment the plan of action to prevent future issues.**

Patient Name _____

Social Worker/Physician _____

Professional Assessment: _____

Social Worker/Physician Signature

Date

Do not complete below this line - Kidney Foundation use only

Monthly Income \$ _____ Expenses \$ _____ Available \$ _____
Yearly Income \$ _____

Meets Lake County Threshold? Yes or No

		Annual Total	
Medication Assistance	Y/N	\$ _____	\$ _____ Per six months
Transportation Assistance	Y/N	\$ _____	\$ _____ Per month
Emergency Assistance	Y/N	\$ _____	\$ _____ One-time payment

Comments _____

Lake County Approval _____ Date _____

Program Services Signature _____ Date _____

Only complete the sections you are applying for assistance

Medication Assistance Program

Applying for Medication Assistance Yes ___ No ___

Did patient receive funding from the Medication Assistance Program in 2021/2022? 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 _____ months

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 Other _____

Did patient receive transportation assistance from the Kidney Foundation of Ohio in 2021/2022? 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) _____

Length of time on dialysis? Please specify _____ years _____ months

Emergency Grant Program

Applying for Emergency Grant Yes ___ No ___

Purpose for emergency assistance: _____

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

Did patient receive emergency assistance in 2021/2022? 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:

How long has the patient been on dialysis? Please specify _____ years _____ months.

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, 2017. 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 if 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: Preston D. Moss, President
Kidney Foundation of Lake County
Phone: (440) 413-3566
kfolake@kfohio.org

Patient Signature _____ **Date** _____