Northeast Kidney Foundation®

PATIENT ASSISTANCE PROGRAMS

Revised July 2011

501 New Karner Road * Albany, NY 12205 * (518) 533-7880 * Fax: (518) 458-9690
www.healthykidneys.org

Northeast Kidney Foundation®

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OVERVIEW

This handbook was written to clarify guidelines for the NeKF Patient Assistance programs. Included in this document is information about guidelines, eligibility, application review and fund disbursement schedule, and required procedures for documentation of expenditures. The goal of this booklet is to:

Provide renal social workers and dietitians with guidelines to assist them in requesting assistance for patients in a systematic, uniform, and fair manner.

The Northeast Kidney Foundation strives to provide high quality programs and services to improve the quality of life for patients and families residing in or receiving treatment in our catchment area.

The NeKF Patient Assistance Programs include emergency grants, transportation subsidies, medical I.D. jewelry and nutrition supplements.

The Northeast Kidney Foundation is committed to ensuring that limited available funds reach patients with the greatest need. Assistance is granted based on demonstrated need and availability of funds and is always at the discretion of the NeKF. It is important for patients, families and healthcare professionals to understand that the NeKF grant programs are <u>not</u> an entitlement program. Funding of one application does not guarantee funding of subsequent applications.

Northeast Kidney Foundation

EMERGENCY GRANTS

PROGRAM GOAL

This program is designed to provide emergency funding to dialysis and kidney transplant patients. The grant should be used for those cases in which an **unforeseen, unexpected crisis has arisen and through the use of this fund, the emergency would be resolved**. It is intended as a one-time source to assist patients and as a means of last resort funding.

POPULATION SERVED

Dialysis and kidney transplant patients who demonstrate financial need and reside within or receive treatment in our service area.

FUNDING

Financial aid is intended for those with limited resources and a documented need. Funds should be requested only after the patient's needs are thoroughly assessed by a social worker and all other possible sources of assistance have been explored. Requests are granted based on demonstrated financial need and the availability of funds.

ELIGIBILITY GUIDELINES

- The specific purpose of this grant is to help in emergency (one-time) situations related to **food, housing and medical stability**. **If the patient has a chronic financial need, it is not appropriate to utilize this resource.**

- All other possible funding sources must be explored before submitting an application. These funding sources should be documented by the social worker on the application form.

- A patient financial information form **must** be filled out and submitted with each application.

- Supporting documentation must be submitted with each application. For example, if assistance is requested in order to pay a utility bill, a copy of that bill must be submitted with the application and patient financial form. If support is requested to pay for medications, a pharmacy receipt or invoice must accompany the application and patient financial form.

- The maximum amount for an emergency grant is $150 during a calendar year.

- Emergency grants cannot be given to individuals while they are receiving NeKF assistance under the transportation subsidy program or the nutrition supplement program. Social workers should wait until individuals are no longer receiving other forms of assistance to submit emergency grant applications.

- **Checks cannot be made payable to patients.** Each application should include the name and address of the service provider, pharmacy, utility company, landlord or other entity to which the check should be made payable. Funding requests for food, if approved by the committee, are given in the form of supermarket gift cards.

- Each application requires detailed information that will give the committee a clear understanding of the applicant's need for emergency funding, including reason for request and current financial standing. Each application requires that a social worker sign off on having viewed documentation of the applicant's financial information.

PROGRAM PROCEDURES

The social worker should complete the **Emergency Grant Application** and either mail or fax the application along with the patient financial information form and supporting documentation to the NeKF office by the 10th of the month. The Programs and Services Committee will review each application and make a determination based on the guidelines outlined in this packet and the information provided by the social worker. Checks or denial notifications will be mailed on the 30th of the month. Applications received after the 10th of the month will be reviewed during the following month.

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**** Emergency Grant Requests Are Approved Based On Demonstrated Financial Need And The Availability Of Funds And Cannot Be Received At The Same Time As Transportation Subsidies Or Nutrition Supplements ****

Emergency Grant Application

Patient Financial Information Form & Supporting Documentation Must Accompany This Application
ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Social Worker:_____ Date:_____

Dialysis/Transplant Unit:_____ Phone:_____

Amount of request:_____ Is NeKF a last-resort funding resource? Yes ___ No ____
Has applicant received an emergency grant before? Yes _____ No _____ If yes, please note when: _____
(month & year)

Amount: _____ Purpose: _____

Is applicant receiving transportation subsidies or nutritional supplement support from NeKF? Yes ___ No ____

Please describe why financial assistance is needed, how funds will be used and other funding sources explored (please continue on the back of this page if more room is needed):_____

Applicant's Name:_____ Age:_____ Sex:_____

Applicant's Home Address:_____

Applicant's Physician:_____

Is applicant employed? Yes____ No____ If yes, Employer's Name & Phone:_____

Is applicant a Medicaid recipient? Yes____ No ____ Explanation:_____

Is applicant a recipient of Medicare? Yes ____ No ____ Explanation:_____

Does applicant have health insurance? Yes ____ No ____ If yes, with what company?_____

If grant is approved, check should be made out to:_____

And sent to:_____

I certify that the information above is correct to the fullest extent of my knowledge, that the above problem is within the scope of the Foundation's Emergency Assistance Program, and that all possible alternative sources of funding have been explored. I understand that requests are approved based on demonstrated need and the availability of funds.

_____
Signature of Social Worker Date

_____
Signature of Applicant Date

For office use only: _____ Financial Form ____ Supporting Documentation

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Transportation Subsidies

PROGRAM GOAL

This program is designed to provide **short term, transitional subsidy funding** to dialysis and kidney transplant patients for transportation to and from their treatment centers. This program is made available to help bridge the first difficult transitional months between relative health and chronic illness and is to be considered as a temporary funding source -- not a long-term entitlement -- and as a source of last resort funding. Grants are issued for a maximum period of six months. Home dialysis patients are eligible for transportation subsidies only during the one or two months of their training period and are treated as monthly payments – so pending funding availability, they would be eligible for up to two transportation subsidy checks.

POPULATION SERVED

Dialysis and kidney transplant patients who meet the established financial eligibility criteria, reside or receive treatment within our service area and travel to and from service facilities for treatment.

FUNDING

Financial aid is intended for those with limited resources and a documented need. Assistance should be requested only after the individual's needs are thoroughly assessed and all other possible sources of funding have been explored. Approved applicants receive a maximum of $60 per month for a 6-month period. Requests are granted based on demonstrated financial need and the availability of funds.

ELIGIBILITY GUIDELINES

- The applicant must be in the first stages of dialysis or transplant status. This is defined as transitioning to dialysis within the initial 6 months of treatment or in the case of home dialysis patients, during the one or two months of their training. This does not apply to a patient transitioning to home dialysis that has been an in center patient for greater than six months.
- The applicant must demonstrate financial need. The patient financial information form must be filled out and submitted with the application.
- All other possible funding sources must be explored before submitting an application. These funding sources should be documented on the application form.
- The maximum amount awarded is $60/month for a 6-month period.
- The applicant must not receive reimbursable transportation assistance from any other source and all avenues for Medicaid reimbursement (which *must* pay for transportation) must be pursued before applying for funds.
- Funds are to be used *only* to subsidize costs for transportation (i.e., cabs, paratransit and public transit) or to subsidize the costs for gasoline to and from treatment sites and it is expected that the most economical mode of transportation will be used.
- All applications require the social worker to sign off on having viewed supporting documentation and patient financial information.

PROGRAM PROCEDURES

- If approved, the applicant receives funding each month for a 6-month period. The social worker must notify NeKF of any change in the applicant's status so that payment may be adjusted. (eligibility criteria, check amount, when a dialysis patient becomes a transplant recipient or vice-versa, etc.).
- Applications must be received by the NeKF office by the 10th of the month to be considered during that month. Checks will be mailed on the 30th of each month. Applications received after the 10th of the month will not be reviewed until the following month.

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**** Transportation Subsidy Requests Are Approved Based On Demonstrated Financial Need And The Availability Of Funds ****

Transportation Subsidy Application

Patient Financial Information Form Must Accompany This Application.

Dialysis Start Date:	Date of Transplant Surgery:
Date of Application:	Physician's Name:
Social Worker:	Phone:
Facility:	Type of Dialysis:
Applicant's Name:	
Applicant's Home Address:	
Medical Status: □ Dialysis Patient □ Kidney Transplant	

Please describe other funding sources explored, why financial assistance is needed and how funds will be used:

_____

_____

_____

_____

Does applicant qualify for Medicaid? _____Yes _____No
Is NeKF a last-resort funding resource? _____Yes _____No

How many times per week does applicant travel to facility? _____
How many miles from applicant's home to facility (one way)? _____

Applicant is requesting (check one):

A. _____ Fuel/Toll(S) Subsidy $_____Round Trip
B. _____ Public Transit/Paratransit Subsidy $_____Round Trip
C. _____ Taxi Subsidy $_____Round Trip

Applicant's average weekly transportation expense: $_____
Requested monthly subsidy amount: $_____

I certify that the information above is correct to the fullest extent of my knowledge and that all alternative sources of funding have been explored. I understand that the Transportation Subsidy Grant is a ***transitional and temporary*** *funding source for applicants, generally for a period of no more than six months. I further understand that requests are approved based on demonstrated financial need and the availability of funds.*

Signature of Applicant_____Date_____

Signature of Social Worker_____Date_____

For office use only:	Financial Form	Supporting Documentation

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Medical I.D. Jewelry Program

PROGRAM GOAL
Provide medical I.D. jewelry (bracelets or necklaces) at no cost to dialysis patients and transplant recipients residing in the NKFNENY 18-county service area.

POPULATION SERVED
Dialysis or kidney transplant patients.

ELIGIBILITY CRITERIA AND PROGRAM PROCEDURES

- As stated above, patients must reside in or receive treatment within the 18-county service area and must be a dialysis patient or a transplant recipient.

- Facility social workers are provided with order forms (there are separate forms for bracelets and necklaces). Patients should complete the forms with assistance from a social worker or nurse.

- Completed forms should be sent to the NKFNENY office via mail or fax. Once a month, the NKFNENY sends a bulk order of I.D. tags to the supplier.

- Engraved I.D. tags are sent to the NKFNENY office and subsequently mailed to the patient's home address unless otherwise instructed.

- Patients are responsible for checking the I.D. tag for errors and for discontinuing use of the tag if their condition changes.

- The NKFNENY pays for the Medical I.D. jewelry and shipping -- there is no charge to the patient.

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EMERGENCY MEDICAL I.D. ORDER FORM

NECKLACE

INSTRUCTIONS: Please fill in the following information thoroughly and neatly. Engraving information **is not to exceed the designated number of spaces per line**. PLEASE NOTE THAT THERE ARE SEPARATE FORMS FOR THE BRACELET AND THE NECKLACE.

PRINT OR TYPE

Dialysis facility contact person (nurse, social worker):_____

Facility:_____ Phone:_____

Facility Address:_____

Physician's Name:_____

Patient's Name:_____

Patient's Home Address:_____

Engraving Information (ONE CHARACTER OR SPACE PER BOX):

NECKLACE - FRONT

1																		
2																		
3																		
4																		
5																		
6																		
7																		

NECKLACE - BACK

1																		
2																		
3																		
4																		
5																		
6																		
7																		

NOTE: Patients are responsible for discontinuing use of jewelry if medical conditions change. Return form to appropriate office address listed above.

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EMERGENCY MEDICAL I.D. ORDER FORM

BRACELET

INSTRUCTIONS: Please fill in the following information thoroughly and neatly. Engraving information **is not to exceed the designated number of spaces per line**. PLEASE NOTE THAT THERE ARE SEPARATE FORMS FOR THE BRACELET AND THE NECKLACE.

PRINT OR TYPE

Dialysis facility contact person (nurse, social worker):_____

Facility:_____ Phone:_____

Facility Address:_____

Physician's Name:_____

Patient's Name:_____

Patient's Home Address:_____

The standard size of the bracelet is 8 inches from the tip of the clasp to the tip of the last link. If the patient requires a larger or smaller size, please indicate the length in inches: _____

Engraving information (ONE CHARACTER OR SPACE PER BOX):

BRACELET - FRONT

1																	
2																	
3																	
4																	
5																	

BRACELET - BACK

1																	
2																	
3																	
4																	
5																	

NOTE: Patients are responsible for discontinuing use of jewelry if medical conditions change.
Return form to appropriate office address listed above.

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Nutrition Supplement Program

PROGRAM GOAL
This program is designed to provide short-term assistance to dialysis patients who suffer from malnutrition or who are in danger of suffering from malnutrition, and demonstrate financial need.

POPULATION SERVED
Dialysis patients who meet the established financial and nutritional eligibility criteria and reside or receive treatment within the Affiliate service area.

FUNDING
Two cases of nutritional supplements may be requested only after the applicant's needs are thoroughly assessed by a dietitian and social worker and all other possible sources of assistance have been explored. Dietitians must reassess patients' nutritional needs and reapply for assistance as appropriate. Funding is offered on a sliding scale basis. Requests are granted based on demonstrated nutritional and financial need and the availability of funds.

ELIGIBILITY GUIDELINES
- The applicant must have an albumin below 3.5 when calculated by the BCG Method or 3.2 when calculated by the BCP Method, documented by a dietitian or physician. It is preferred that documented albumin levels are provided for a period of at least three (3) months. If this amount of documentation is not available, please provide as much data as possible.
- The applicant must reside or receive treatment within the 18-county region served by the NeKF.
- The applicant must demonstrate financial need. The patient financial information form must be filled out and submitted with the application.
- All other possible funding sources must be explored before submitting an application. These funding sources should be documented on the application form.
- All applications require a dietitian or physician to sign off on nutritional eligibility and a social worker or dietitian to sign off on having viewed documentation in support of the patient financial information form.

PROGRAM PROCEDURES
- A dietitian or physician must determine and document a patient's nutritional eligibility before submitting an application for nutrition supplements.
- The social worker and/or dietitian should use the sliding scale chart to determine whether a patient meets the funding criteria before submitting an application. If the patient meets the criteria, the social worker or dietitian must use the sliding scale chart to determine the patient's required financial contribution. The patient's contribution will be due upon notification that the request has been approved.
- If approved, **two cases** (48 cans) of Nepro will be shipped directly to the dialysis unit for distribution to the patient by the dietitian. Nepro is available in Vanilla, Butter Pecan and Mixed Berry. Dietitians may reapply for assistance on behalf of patients as necessary.
- Applications must be received by the NeKF office by the 10th of the month to be considered for receipt of the supplements during the following month. Applications received after the 10th of the month will not be reviewed until the following month.

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**** Nutrition Supplement Requests Are Approved Based On Demonstrated Nutritional And Financial Need And The Availability Of Funds ****

Nutrition Supplement Program Application

Patient Financial Information Form Must Accompany This Application.

Application Status: ☐ New ☐ Renewal - Months/Years Supplements Last Received: _____

Dietitian: _____ Social Worker: _____

Dialysis Unit: _____ Phone: _____

Patient's Name: _____ Phone: _____

Address: _____

Date of Birth: _____ Date Dialysis Began: _____

Estimated Dry Weight_____Height_____ (Check if amputations make BMI indexing invalid.) _____

Patient's Physician _____ Phone: _____

Is applicant a Medicaid recipient? Yes____No _____Explanation: _____

Is NKFNENY a last-resort funding resource? Yes ____ No _____ If no, explain why the needs of the applicant would be better served under this program: _____

Nutritional Basis for Eligibility: Albumin (must be less than 3.2 BCP Method or 3.5 BCG Method)

Month 3: _____ Method: _____ Date recorded: _____
Month 2: _____ Method: _____ Date recorded: _____
Month 1: _____ Method: _____ Date recorded: _____

Patient Financial Obligation: _____ Flavor (Circle One): **Vanilla** **Butter Pecan** **Mixed Berry**
(Figured from sliding scale chart on page 9

I certify that the information above is correct to the fullest extent of my knowledge and that all possible alternative sources of funding have been explored. I understand that requests are approved based on demonstrated need and the availability of funds.

Dietitian or Social Worker Signature _____ Date _____

Physician Signature _____ Date _____

I wish to apply for one month of nutrition supplement assistance. I understand that initial and ongoing eligibility is based largely on my medical condition and I give approval to this dialysis clinic to release information about me relevant to this program to the Northeast Kidney Foundation (NeKF). I understand that the NeKF may use my **non-identifying information** combined with that from others to evaluate and demonstrate program effectiveness. In addition, I understand that my identity (but not my medical condition) may be compared with persons on other ongoing supplement programs to avoid duplication of services.

Applicant Signature _____ Date _____

For office use only:	Financial Form	Supporting Documentation

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Nutrition Supplement Sliding Scale Fee Chart

Instructions: Find patient's income and family size on the chart to determine patient's financial obligation. To determine income for use with this chart, fill out the Patient Financial Information Form and utilize the formula at the bottom.

Family size	Income Levels				
1	17,000 or less	17,001-22,000	22,001-25,000	25,001-27,000	27,001-29,000
2	24,000 or less	24,001-29,000	29,001-32,000	32,001-34,000	34,001-36,000
3	31,000 or less	31,001-36,000	36,001-39,000	39,001-41,000	41,001-43,000
4 or more	38,000 or less	38,001-43,000	43,001-46,000	46,001-48,000	48,001-50,000
Patient obligation (for 2 cases)	$10	$20	$30	$40	$50

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Patient Financial Information Form

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Monthly Income	
Patient's Monthly Take-Home Pay	**$**
Spouse/Partner's Monthly Take-Home Pay	**$**
Additional Income	
Social Security	**$**
Aid to Dependent Children	**$**
Retirement Benefits	**$**
Veteran's Benefits	**$**
Other (Specify)	**$**
Total Monthly Income	**$**

Family Size: _____

Monthly Household Expenses	
Rent	**$**
Mortgage	**$**
Food	**$**
Telephone	**$**
Utilities (electric/gas/oil/water)	**$**
Car Payment	**$**
Gasoline/Bus/Taxi	**$**
Credit Cards	**$**
Loans	**$**
Other (Specify)	**$**
Monthly Insurance Expenses (Excluding Health & Dental)	
Life	**$**
Auto	**$**
Other	**$**
Monthly Medical Expenses	
Patient's Medication	**$**
Family Members' Medication	**$**
Health (include dental)	**$**
Total Monthly Medical Expenses	**$**
Total Monthly Expenses	**$**

For Nutrition Supplement Applications Only

Calculate net income using the following formula and then refer to the sliding scale fee chart on page 10 to determine patient obligation:

(Total Monthly Income x 12) minus (Total Monthly Medical Expenses x 12) = _____