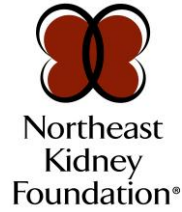


Northeast  
Kidney  
Foundation®

# PATIENT ASSISTANCE PROGRAMS

*Revised September 2020*

Albany \* 22 Colvin Avenue \* Albany, NY 12206  
Syracuse \* 731 James Street, Suite 408 \* Syracuse, NY 13203  
Rochester \* 95 Allens Creek Road, Building 1 Suite 323 \* Rochester, NY 14618  
[www.healthykidneys.org](http://www.healthykidneys.org) \* 800-999-9697 \* [info@healthykidneys.org](mailto:info@healthykidneys.org)



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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 not an entitlement program. Funding of one application does not guarantee funding of subsequent applications.**



## **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 10<sup>th</sup> 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 30<sup>th</sup> of the month. Applications received after the 10<sup>th</sup> of the month will be reviewed during the following month.



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[www.healthykidneys.org](http://www.healthykidneys.org) \* [info@healthykidneys.org](mailto:info@healthykidneys.org)

**\* 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 |
|--|



## **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 10<sup>th</sup> of the month to be considered during that month. Checks will be mailed on the 30<sup>th</sup> of each month. Applications received after the 10<sup>th</sup> 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: <input type="checkbox"/> Dialysis Patient <input type="checkbox"/> 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 \_\_\_\_\_



## 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 NKFENY 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 NKFENY office via mail or fax. Once a month, the NKFENY sends a bulk order of I.D. tags to the supplier.
- Engraved I.D. tags are sent to the NKFENY 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 NKFENY 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.



## 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 10<sup>th</sup> of the month to be considered for receipt of the supplements during the following month. Applications received after the 10<sup>th</sup> 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 NKF/NENY 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 |
|----------------------|----------------|--------------------------|



## 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<br>or less | 17,001-<br>22,000 | 22,001-<br>25,000 | 25,001-<br>27,000 | 27,001-<br>29,000 |
| 2                                      | 24,000<br>or less | 24,001-<br>29,000 | 29,001-<br>32,000 | 32,001-<br>34,000 | 34,001-<br>36,000 |
| 3                                      | 31,000<br>or less | 31,001-<br>36,000 | 36,001-<br>39,000 | 39,001-<br>41,000 | 41,001-<br>43,000 |
| 4 or<br>more                           | 38,000<br>or less | 38,001-<br>43,000 | 43,001-<br>46,000 | 46,001-<br>48,000 | 48,001-<br>50,000 |
| Patient<br>obligation<br>(for 2 cases) | \$10              | \$20              | \$30              | \$40              | \$50              |



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**Patient Financial Information Form**  
*ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL*

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

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

**Family Size:** \_\_\_\_\_

**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) = \_\_\_\_\_





## DIALYSIS HOPE TOTE PROGRAM

The Dialysis Hope Tote program is for those within the first 30 days dialysis. Upon request, a patient will receive a tote bag with educational information and descriptions of the services that are available to them through the Northeast Kidney Foundation. Each bag contains:

- The book “You are a Dialysis Patient” authored by nephrologist Dr. James Horn.
- The NEKF’s Renal Exchange booklet.
- One sheet educational information on the importance of fluid intake and also the importance of not missing dialysis treatments.
- Hand sanitizer
- Medicine boxex
- Grocery shopping lists
- Mints
- An NEKF brochure and flyers on services that are available.
- Other informational flyers as needed depending on time of year and late breaking events.

To request a copy of a Hope Tote for your patient, complete the information below:

Unit Name: \_\_\_\_\_ Social Worker Name \_\_\_\_\_

Date patient began dialysis \_\_\_\_\_

Unit address: \_\_\_\_\_

Social Worker Phone and Email: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Return to: Northeast Kidney Foundation, 22 Colvin Avenue, Albany NY 12206; email [info@healthykidneys.org](mailto:info@healthykidneys.org); [www.healthykidneys.org](http://www.healthykidneys.org)



The NEKF offers patients a number of free publications available for download at [www.healthykidneys.org](http://www.healthykidneys.org) under the Programs and Services/Publications Tab.

These include our newsletter, You are a Dialysis Patient book, Renal Exchange booklet, Mental Health Resource Kit for the Capital Region, Syracuse and Rochester markets, and a depression screening tool.

We also offer a number of informational sheets on high blood pressure, diabetes, types of dialysis, transplantation and other topics.

We are continually updating our website. If there is an area of interest that we may be able to add, please email [info@healthykidneys.org](mailto:info@healthykidneys.org).

You may address mail to any one of our offices:

NeKF Headquarters  
22 Colvin Avenue  
Albany, NY 12206

Syracuse Office  
Northeast Kidney Foundation  
731 James Street Suite 408  
Syracuse, NY 13203

Rochester Office  
Northeast Kidney Foundation  
95 Allens Creek Road  
Building 1, Suite 323  
Rochester, NY 14618

Visit us on the web at [www.healthykidneys.org](http://www.healthykidneys.org)



As a patient services organization, the NeKF offers a variety of programs and services to patients and family members. We strive to be an extended support network for you. Here are a sampling of the things we offer for patients and family members:

**Kidney Club Support Group** – virtual meetings are held the 2<sup>nd</sup> Sunday of every month from 12 noon until 2 pm.

**Real Kidney Living Podcast** – available on Apple, Spotify and I Tunes, new episodes drop on the 1<sup>st</sup> and 3<sup>rd</sup> Wednesday of the month. Our podcast explores topics ranging from the kidney diet to treatment options to transplant to pediatric issues and everything in between! Moderated by two time kidney recipient Douglas Brown, the podcast seeks to inspire, uplift and help everyone along their kidney journey!

**Cooking for Your Kidneys** – patients, family members, clinicians and others can join us for monthly cooking demonstrations with our kidney chef John Vito. He is a restaurateur, chef, former dialysis patient and now transplant recipient. He combined his love of food with food science and the inside scoop on the kidney diet to bring you kidney healthy recipes and tips that help you navigate the ever complex kidney diet.

**Having Your Kidney Donor Find You** – through a partnership with the Living Kidney Donor Network, the NeKF offers this online educational program designed to help those waiting for a transplant find a potential living kidney donor.

**Kidney Caregiver Program** – the Kidney Caregiver program is designed to help patients dealing with isolation or those that simply want someone to chat with in an informal manner. Trained volunteers are matched with patients to conduct regular friendly telephone visits and provide moral support that can help make the kidney journey a bit easier!

**Scholarships** – each year we present the Shane Leone Memorial Scholarship to young adults affected by kidney disease. Scholarships range from \$1000 - \$1500. Applications are accepted from January – March and award announcement is made in April.

**Advocacy** – as a patient advocacy organization, we work with our state and federal legislators to help ensure they are making sound healthcare decisions. We offer commentary on a number of pieces of legislation each year and also work with patient advocacy organizations across the state to represent the interests of kidney and transplant patients.