Revised March 2015

DAILY LIVING NEEDS PROGRAM
GUIDELINES AND APPLICATION

PROGRAM ELIGIBILITY

The Alabama Kidney Foundation Daily Living Needs Assistance Program provides financial assistance for Alabama residents with end stage renal disease, as diagnosed by a physician. Patients must apply for assistance through a licensed social worker; the Foundation has no direct contact with the patient.

Income Guidelines

1 Person Household	$1,000 monthly
2 Person Household	$1,200 monthly

APPLICATION PROCESS

The Foundation will respond only to cases that have been evaluated and referred by a licensed social worker. The application must be printed or typed, filled out completely and faxed or mailed with any supporting documentation that would assist in its evaluation. An incomplete or ineligible application will be returned. The referring professional is encouraged to provide as much information as possible in the application (cover letter/detailed financial overview/expense documentation). **Refer to the checklist to assure that all needed information is provided**. An information-packed application has a much better chance of approval!

ASSISTANCE APPLICATIONS WILL BE CONSIDERED FOR THE FOLLOWING:

- **MEDICATIONS:** Patient has no other means or mechanism (i.e. pharmacy credit/family assistance/physician samples/other local social service assistance program) for obtaining required prescription medication.
- **MEDICAL EQUIPMENT:** Patient has no other means or mechanism (i.e. provider credit/family assistance/other local social service assistance program) for obtaining required prescription medical equipment.
- **DENTAL OR OPTICAL:** Patient has no other means or mechanism (i.e. provider credit/family assistance/other local social service assistance program) for obtaining required dental or optical services.
- **UTILITIES (excluding deposits and telephone):** Patient has no other means or mechanism (i.e. family assistance/utility assistance program/other local social service assistance program) for avoiding termination/reestablishment of utility service.
- **MINOR MEDICAL PROCEDURE:** Patient has no other means or mechanism (i.e. provider credit/family assistance/other local social service assistance program) for obtaining required medical procedure.
- **EMERGENCY TRANSPORTATION**: Please forward non-emergency transportation requests to the Alabama Kidney Foundation's Treatment Related Transportation Program, using the appropriate program application form.

PATIENT SERVICES REVIEW COMMITTEE

The Patient Services Review Committee is made up of five groups of service professionals. Applications for assistance are screened to assure that all components are included. Completed applications are forwarded to one of the six groups for review. The Foundation endeavors to respond to all non emergency requests within four business days of receiving eligible and completed application. In the case of a utility disconnect notice, the social worker should see that a request for an extension has been made before presenting the application to AKF.

OTHER GENERAL GUIDELINES TO OBSERVE:

1. **Please be advised that no patient is ENTITLED to any specific amount of assistance through this program.** Applications will be evaluated with criteria that will focus primarily on the strength of the need presented (as perceived by the committee). Resources will be assigned based on availability.

2. The referring professional **must seek help through at least two other sources** of community-based assistance before appealing to the Foundation Daily Living Needs Program. These resources must be listed on the application form stating the amount provided/pledged or an explanation as to why none was available/appropriate for the case in question.

3. The referring professional should encourage the patient to utilize providers who offer supplies and/or services at a competitive rate. Generic medications should be requested unless the generic version is considered to be of significantly less quality.

4. Applications for assistance must include all four components of the Daily Living Needs Program **Application Form completed and legible and a statement from the service/product provider with legible address**. All components of the application must be received in the office before it will be presented to the committee for review. Applications that are complete and in order expedite the process for everyone concerned. If the patient fills out the application the referring professional should review all information before presenting it to the Foundation Daily Living Needs Program.

DISBURSEMENT PROCESS

Assistance checks will be made payable to a service/product provider only. When an application is approved and processed, payment will be mailed directly to the service/product provider and the referring professional will receive verification of payment via mail or email.

If an application is denied, the referring professional will be notified by e-mail.

ASSISTANCE LIMITS

Assistance is limited to $300.00 per patient per calendar year through the Daily Living Needs Program.

DAILY LIVING NEEDS APPLICATION FORM

PATIENT INFORMATION

Date of Application:_____/___/

Patient's Name: _____
(Last Name) (First Name)

Patient's Address: _____
Street City State Zip

Home Phone: _____ **Social Security Number:**_____.____._____.

Dialysis Unit Serving Patient: _____

Dialysis Unit Address: _____
Street City State Zip

Dialysis Unit Telephone Number: _____ **FAX Number:** _____

Name of Physician: _____

Name of Social Worker: _____
Please Print

If financial need exceeds $300, verification must be provided that the patient has made payment arrangements with the service provider, procured assistance from other legitimate resources, or paid the remaining balance. Please note that applications without substantiating verification will result in denial of assistance. Decisions will be made at the discretion of the Patient Aid Review Committee in accordance with the information provided.

I hereby authorize the assisting professional to provide the Alabama Kidney Foundation with all information available regarding myself, my spouse and/or my children as required to properly evaluate my application for financial assistance. In submitting this information, I guarantee its accuracy and truth with the intent that it be relied upon by the Alabama Kidney Foundation in considering the requested assistance. I also agree that the information in this application may be verified.

Patient Signature/Mark: _____ **Date:**____/____/____

Only office personnel will have access to this information.

DEMOGRAPHICS **Date:** _____

Resident County: _____ **Age:** _____ **Sex: [ ] Male [ ] Female**

Race: (African American) ____ **Cauc)** ____ **(Hisp)** ____ **(Asian)** ____ **(Amer. Ind.)** ____ **(Other)** _____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Dependents: [ ] No [ ] Yes If "Yes", give age of each _____

TX Modality: [ ] Hemo [ ] Peritoneal [ ] Transplanted [ ] Other Number yrs. on dialysis _____

Amount of previous assistance within calendar year: $ _____

Amount Requested $ _____ **Amount of Statement $** _____

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Please describe IN DETAIL, circumstances outside the norm that necessitated the need at this time. Use additional page if necessary. Use name of patient in designated places only.

- **Request must include statement from service/product provider with legible address.**
- **In the case of a disconnect notice the social worker should see that a request for an extension is made prior to presenting the application. Note refusal or date of extension if granted.**

Please identify TWO other relevant community resources that were contacted PRIOR to requesting assistance from AKF. Identify what help was provided/pledged OR explain why such services were denied.

1st Option: _____

2nd Option _____

Patient's Ins. Coverage _____

_____ **Patient's Prescription Drug**

Plan _____

Initials of patient: _____

PLEASE ATTACH ALL RELEVANT DOCUMENTATION WHEN SUBMITTING THE APPLICATION INCLUDING PROVIDER'S STATEMENT WITH LEGIBLE ADDRESS

SOURCES OF INCOME/EXPENSE

Sources of Monthly Income

___ Not employed _____

___ Employed _____

___ Spouse _____

___ Other living in home _____

___ SSI _____

___ SSD _____

___ IRA _____

___ Pension _____

___ Retirement _____

List Other Income Sources

___ Child Support _____

___ Company Disability _____

___ Medicaid NET _____

___ Food Stamps _____

___ Welfare _____

___ Veteran's Benefits _____

___ AKF Travel _____

___ Other _____

MONTHLY TOTAL _____

Patient's Initials: _____

Monthly Expenses

___ Rent/Mortgage _____

Utilities

___ Electric _____

___ Gas _____

___ Water _____

___ Telephone _____

___ Cable/Satellite _____

___ Food _____

___ Clothing _____

___ Household Supplies _____

Insurance (combined) _____
(Life/Auto/Homeowner's/Rental)

___ Automobile Loan _____

___ Gasoline _____

___ Auto Maintenance _____

___ TX Related Travel _____

___ Medications _____

___ Other (explain) _____

MONTHLY TOTAL _____

Social Worker's Initials: _____

If monthly expenses exceed monthly income by $300 or more, please explain.

_____

_____

_____

ALABAMA KIDNEY FOUNDATION

Daily Living Needs Guidelines Checklist (to be completed by Social Worker)

****Please check all items before presenting application to AKF.**

Guidelines/Comments	Yes	No	N/A
Is the application referred by a licensed Social Worker?			
Is the application filled out completely?			
Is the application legible (including address of provider of service)?			
Is this a qualifying request?			
Considered: Medications, medical equipment, dental, utilities, minor medical procedures. Other miscellaneous requests will be considered at the discretion of the committee.			
Not Considered: Rent, telephone, deposits, post mortem expenses			
Has enough information been presented to necessitate the request?			
Are all required documentation provided?			
Were at least two other community resources contacted?			
If NO to above, was an explanation provided?			
Do monthly expenses and income fall within a $300 range?			
If NO to the above, was an explanation provided?			
Does the amount of the request fall within the $300 per year maximum allocation?			
If NO to the above, has verification of payment arrangements with the vendor or receipt of balance paid been included with the application?			
Has request been made for extension on utilities disconnect?			

ADDITIONAL COMMENTS:

_____

_____

_____

Signature of Social Worker: _____

Initials of Patient: _____

ALABAMA KIDNEY FOUNDATION

THIS FORM MUST ACCOMPANY EACH FINANCIAL ASSISTANCE REQUEST.

Financial Assistance Program Goal
The goal of the Alabama Kidney Foundation's financial assistance programs is to assist patients avert a financial hardship so that they can experience life to its fullest.

Evaluating Effectiveness
The financial assistance program's effectiveness is measured by feedback provided by the patient and assisting social worker.

Outcome Measure Statement
The granting of this request for financial assistance will help to alleviate a financial hardship for this patient.

Patient response

- ☐ Yes
- ☐ No

Date: _____

Social Worker: _____

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