Kidney Foundation of Western New York

Patient Support Programs

The Kidney Foundation of WNY is dedicated to increasing community awareness of kidney disease while educating, supporting and advocating for those we serve.

In keeping with this mission, the foundation offers support to patients with limited means within the eight counties of Western New York. Requests for the below services should be made through patients' social workers. The Patient Support Committee reviews the summaries of applications with identifying details omitted. Assistance is granted based upon patient need and the availability of funds.

Social workers may send applications to Bridget English by email at assistance@kfwny.org, by fax at 716-529-4391 or by mail to Kidney Foundation of WNY, 4444 Bryant and Stratton Way, Williamsville, NY 14221. Voicemail messages for the Kidney Foundation can be left at 716-529-4390.

Patients' personal information will be kept confidential. Non-identifying information will be used to evaluate program effectiveness and report upon the program's reach.

Emergency Financial Assistance
Financial assistance grants are provided to dialysis and kidney transplant patients to assist with short-term, one-time emergency needs such as food, utility payments, rent and/or medication. The maximum grant amount is $150 per patient per year. Payments will be made to vendors, not to the patient. Emergency financial assistance that overlaps with an individual's use of the Kidney Foundation of WNY Transportation Assistance or Nutritional Supplement programs will be limited to a cumulative total of $150.

Nutritional Supplements
Nutritional renal supplements are provided on a short-term basis to dialysis patients in order to prevent or treat nutritional deficits. The Kidney Foundation of WNY will send packages of supplement powders and/or drinks to the patient's dialysis center.

Transportation Assistance
Short-term grants are available to dialysis and transplant patients to offset the cost of transportation to and from treatment centers. The grant can cover a limited period at a maximum of $150 per year. The assistance is meant only to subsidize the cost of transportation (such as paratransit and public transit) or gasoline to and from treatment sites.

4444 Bryant and Stratton Road, Williamsville, NY 14221
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Emergency Financial Assistance Application

Financial assistance grants are provided to dialysis and kidney transplant patients to assist with short-term, one-time emergency needs such as food, utility payments, rent and/or medication. The maximum grant amount is $150 per patient per year. Payments will be made to vendors, not to the patient. Emergency financial assistance that overlaps with an individual's use of the Kidney Foundation of WNY Transportation Assistance or Nutritional Supplement programs will be limited to a cumulative total of $150 per year.

Date of Application:_____
Patient's Name:_____
Patient's Home Address: _____
Phone number: _____
Social Worker name:_____
Facility name:_____
Phone number: _____

Need for which funds will be used:_____
(Please provide detail of the need for emergency funding)_____
_____

Amount of request:_____
($150 is maximum amount)

If approved, check will be made out to:_____
Check cannot be made out to patient; must be a company/business. Funding requests for food can be given in the form of supermarket gift cards.
Address for check:_____

Has the patient received previous emergency grants? Yes____No____
If yes, please note month and year:_____

Have other funding sources been explored? Yes_____No_____Explanation:_____
_____
_____

In submitting this application, I guarantee its truth and accuracy to the fullest extent of my knowledge. The patient also agrees that the information in this application may be verified.

_____
Signature of social worker Date

Office Use Only

Approved by_____ Date_____

Revised 7/2026

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Nutritional Supplement Application

Nutritional renal supplements are provided on a short-term basis to dialysis patients in order to prevent or treat nutritional deficits. If an application is approved, the Kidney Foundation of WNY will send 24 units of supplement powders and/or drinks to the patient's dialysis center, to be distributed to the patient by the dietitian. The dietitian or social worker may reapply if continued assistance is needed.

The patient 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. Please include documentation of albumin levels for a period of three months. If this documentation is not available, please provide as much data as possible.

Patient's Name:_____
Patient's Home Address: _____
Patient's Phone: _____

Social Worker name:_____
Social worker phone/email:_____

Facility name:_____
Facility address (supplements will be delivered here):_____
_____
Days and hours of operation:_____
Phone:_____
Dietitian name:_____
Dietitian phone/email:_____

Application status: New____Renewal_____
Month/Year Supplements Last Received:_____
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: _____
Flavor preference (as available): Vanilla___Berry__

In submitting this application, I guarantee its truth and accuracy to the fullest extent of my knowledge.

_____
Signature of social worker or dietitian Date

Office Use Only

Approved by_____ Date_____

_____

Revised 7/2026

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Transportation Subsidy Application

Short-term grants are available to dialysis and transplant patients to offset the cost of transportation to and from treatment centers. The grant can cover limited period at a maximum of $150 per year. The assistance is meant only to subsidize the cost of transportation (such as para transit, public transit or car services) or gasoline to and from treatment sites.

Please note: All avenues for other reimbursement should be pursued before applying for this subsidy. Social workers should inform the Kidney Foundation of WNY of any change in a patient's dialysis or treatment status which may affect program eligibility.

Date of Application:_____

Patient's Name:_____
Patient's home address:_____
Patient's Phone: _____
Patient's email address:_____ (needed for Uber or Lyft electronic gift cards)

Social Worker's name:_____
Treatment facility name and address:_____
_____
Phone: _____

Day(s) and time(s) of patient appointment/treatment:_____
If using a transportation service, requested pickup times:_____

Applicant is requesting (check one):

_____ Fuel subsidy (Gas Card)	_____ Public transit subsidy	_____ Taxi/Medical Transport
_____ Gift card (Uber/Lyft/other)	_____ Paratransit subsidy	_____ Wheelchair Med. Transport

Additional details: _____
_____

I certify that the information above is correct to the fullest extent of my knowledge and that all alternative sources of transportation funding/reimbursement have been explored.

_____
Signature of Social Worker Date

Office Use Only

Approved by_____ Date_____

Revised 7/2026