



Grant Application: Home Blood Pressure Monitor

THE KIDNEY FOUNDATION BC & YUKON BRANCH
Suite 200 – 4940 Canada Way
Burnaby, BC V5G 4K6
Phone: (604) 736-9775; Fax: (604) 736-9703
Toll Free Phone: 1-800-567-8112; Fax: 1-800-667-8871

Instructions for Licensed Kidney Care Clinic Health Professional completing this form:

1. Fax or e mail (encrypted) **page 1** (NOT page 2) of this completed form to the patient’s preferred pharmacy from the list of contracted pharmacies. www.bcrenal.ca/resource-gallery/Documents/Community%20Pharmacy%20List.pdf.
2. Fax or e mail (encrypted) **pages 1 and 2** of this form to the Kidney Foundation of Canada (for information).

Instructions for Pharmacies receiving this form:

1. Identify home blood pressure monitor with appropriate cuff size (see dimensions below). Contact patient to confirm purchase and pick-up (if possible). If the cost is higher than identified as the maximum on this form, the patient will be responsible for the additional cost.
2. Every 3 months (Mar 31, Jun 30, Sept 30, Dec 31), send an invoice to the Kidney Foundation of Canada, BC and Yukon Branch for reimbursement of home blood pressure monitors dispensed. Include the names of patients provided with monitors, and the cost.

Kidney Foundation of Canada, BC and Yukon Branch Attention
Heather Johnson
Fax: (604) 736-9703; Email (encrypted): heather.johnson@kidney.ca
Questions: (604) 558-6879 (phone)

Date: _____

Part 1: Patient information

First name: _____ Last name: _____
Date of birth: _____ PHN: _____
Home address: _____ City: _____
Postal code: _____ Phone: _____

Part 2: Kidney Care Clinic Health Professional please enter arm circumference.

BP Device/Cuff

Arm circumference (middle of upper arm at midpoint between shoulder and elbow): _____ cm

Ideal cuff bladder width: Arm circumference x 0.4 = _____ cm (minimum size)

Ideal cuff bladder length: Arm circumference x 0.8 = _____ cm (minimum size)

Pharmacy to identify BP monitor with appropriate cuff size and includes “Recommended by Hypertension Canada” on the monitor or box (silver or gold logo).

| Product | Maximum Approved Amount (excluding GST) |
|---|--|
| BP monitor with cuff | \$60 for device/cuff (if standard cuff size is suitable) \$90 for device/cuff (if an extra small or a large cuff is required) \$200 for device/cuff (if an extra-large cuff is required) |
| BP monitor with verbal assistance (talking monitor) | \$125 |
| BP monitor with pre-formed cuff | \$125 |

Pick-up/Delivery

- Pick-up in store (strongly encouraged)
- Delivery (pick-up not possible within the next month)



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Part 3: Licensed KCC Health Professional (HCP)

| | | |
|--------------------------|--------------------|------------|
| Name of Licensed KCC HCP | Kidney Care Clinic | Signature |
| Phone | Email | Pager/cell |

Continuation of Grant Application

Patient name: _____

Part 4: Grant eligibility (3 boxes must be checked)

Patient of BC Kidney Care Clinic (select one):

- | | |
|----------------------------|------------------------|
| Abbotsford | Penticton |
| BC Children’s | Prince George |
| Campbell River (North Is) | Royal Jubilee |
| East Kootenays (Cranbrook) | St Paul’s Hospital |
| Kamloops | Surrey |
| Kelowna | Van General Hospital |
| Nanaimo | West Kootenays (Trail) |
| New West (Royal City) | Williams Lake |

Table 1

| Living in the Household | | Total monthly net household income is less than.... |
|-------------------------|----------|---|
| Adults | Children | |
| 1 | 0 | \$1,900 |
| 1 | 1 | \$2,200 |
| 1 | 2 | \$2,500 |
| 1 | 3* | \$2,800 |
| 2 | 0 | \$2,200 |
| 2 | 1 | \$2,500 |
| 2 | 2 | \$2,800 |
| 2 | 3* | \$3,100 |

*For every additional child, add \$300 to the total monthly income.

All other reasonable sources of funding have been pursued.

Total monthly net household income is less than the amounts identified in Table 1.

Part 5: Desire for contact by Kidney Foundation

Would the applicant like to receive Kidney Foundation newsletters by e mail?

Yes. E mail: _____ No thanks

Would the applicant like to be contacted by the Kidney Foundation for quality improvement and/or patient-based research purposes?

Yes. Preferred means of contact: _____ No thanks

E mail: _____

Phone: _____