

**Special Assistance Program Family Guidelines**

Welcome to Mothers’ Milk Bank Northeast. We understand that you would like to use pasteurized donor human milk (PDHM) for your baby but it costs too much. We want to send milk to sick babies regardless of income. In order to help as many babies and families as possible, we can send up to 4 weeks of milk through our Special Assistance Program (SAP).

Included in this e-packet are:

1. **Special Assistance Program Application**

* Fill this out and send it back to us.
* Include one financial document (the application explains this).

1. **Requirements for Letter of Medical Necessity**
2. **Prescription Form**

* Give these two documents to your baby’s doctor.
* Ask them to fax the letter and prescription back to us.

Once we receive all the forms back, our doctors will review your doctor’s letter.

When we have reviewed everything, we will contact you to talk about payment and shipping plan.

Please tell us if there are any changes in your insurance or your family situation.

We are looking forward to working with you.

**How to send the forms (choose one):**

* **Fax to** 617-527-1005 (your doctor’s office may be able to help with this).
* **Email** to [sap@milkbankne.org](mailto:sap@milkbankne.org) (email is not secure so we do not recommend this).
* **Drop off or mail** to Mothers’ Milk Bank Northeast, 377 Elliot Street, Newton Upper Falls, MA 02464.

**Questions?** Call 617-527-6263 x5 and ask for SAP or email [sap@milkbankne.org](mailto:sap@milkbankne.org).



**Special Assistance Program Application**

Name:

Address:

City, State, Zip:

Phone:

Email:

Baby’s name and date of birth:

What is your annual household income? Net: \_\_\_\_\_\_\_\_\_\_\_\_ Gross: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the names of all household members and relationship to the baby:

Name Relationship

**REQUIRED FINANCIAL ATTACHMENT** (provide at least one document):

Please attach proof that you are a participant in one of these programs:

\_\_\_\_Supplemental Nutrition Assistance Program (SNAP)

\_\_\_\_Women, Infants, and Children (WIC) Program

\_\_\_\_Medicaid or state-sponsored insurance

\_\_\_\_Subsidized housing

\_\_\_\_Other public assistance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not a participant in any of these assistance programs, please provide:

\_\_\_\_The first page of your tax return

\_\_\_\_Pay check stubs (one for each wage-earner in household)

\_\_\_\_Other proof of income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL STATEMENT**

Why are you requesting donor milk?

Are there unusual expenses or circumstances that make it more difficult for you to pay the donor milk fees?

We look forward to working with you to ensure that your baby receives the donor milk that he or she needs to continue to grow and thrive.



**Requirements for a Letter of Medical Necessity**

*\*Time-sensitive\**

***Parents:*** *Please fill in baby’s name and date of birth and give this form and the prescription form to your baby’s doctor.*

**Baby’s name and date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your patient’s family would like to order Pasteurized Donor Human Milk (PDHM) from Mothers’ Milk Bank Northeast. We need a **letter of medical necessity** and a **prescription** from you in order to process their application for financial assistance. When writing the letter, please include the following information:

* Birth History, including:
  + Date of birth
  + Gestation age at birth
* Growth History
  + Birth weight
  + Current weight
* Medical conditions and diagnosis
* Complications for baby after birth, may include:
  + Surgeries
  + Infections in GI tract
* Medications
* Formula trials, including:
  + Name of formulas
  + Volume
  + Length of time for each trial
  + Effect on baby
* Additional information you believe will be valuable
* Weaning plan to transition off of donor milk

**Please fax** the completed letter and prescription to 617-527-1005, att: SAP.

**Questions?** Call 617-527-6263 x5 and ask for SAP (Special Assistance Program) or email [sap@milkbankne.org](mailto:sap@milkbankne.org).

**Learn more about our milk bank** by visiting **milkbankne.org**.

**PRESCRIPTION FORM FOR PASTEURIZED DONOR HUMAN MILK (PDHM)**

*Healthcare providers: You can use your own prescription forms. Please include all the information listed below*.

*Fax prescription to Mothers’ Milk Bank Northeast.*

**Fax: 617-527-1005**

BABY’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide ad lib amounts of PDHM for \_\_\_\_\_\_\_\_ weeks (1 to 4) \_\_\_\_\_\_\_\_ months (1 to 12) for the following reasons:

\_\_\_ Prematurity \_\_\_ Cleft Lip/Palate \_\_\_ Hypoglycemia

\_\_\_ Low Milk Supply \_\_\_ Adopted Child \_\_\_ Frenulum Restriction

\_\_\_ Weight Loss \_\_\_ Multiple Gestation \_\_\_ Hyperbilirubinemia

\_\_\_ Maternal Health Complications \_\_\_ Failure to Thrive \_\_\_ GI Issues/Feeding Intolerance

\_\_\_ SGA/IUGR \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide details here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare provider:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name or Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardians:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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