Mothers' Milk Bank Northeast
*Share the Health*

## Critical Access Resource Equity Subsidy (CARES)

## Family Guidelines

We understand that your baby medically requires donor milk and that it is cost prohibitive. For families with both a documented family financial need and a medical need on the part of the baby, we have a subsidy program available that can provide up to 4 weeks of milk (typically 10 100ml bottles per week) for babies who qualify.

Included in this e-packet are:

1. **CARES Application**
   - Parent/guardian fills this out and send it back to us.
   - Include one financial document (the application explains this).

2. **Verification of Medical Necessity Form** (completed by physician)

3. **Physician Request Form** (completed by physician)
   - Give these two documents to your baby's doctor.
   - Ask them to fax the forms to us.

Once we receive your forms, we will review your application for assistance and make a determination about eligibility.

**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 cares@milkbankne.org
- **Drop off or mail** to Mothers' Milk Bank Northeast, 377 Elliot Street, Newton Upper Falls, MA 02464.

**Questions?** Call 617-340-3497 and ask for CARES or email cares@milkbankne.org.

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## CARES Application (to be completed by family)

Parent/Guardian 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

□Paycheck 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 afford donor milk?

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## Verification of Medical Necessity Form (to be completed by pediatrician)

**Baby's name: _____**

Your patient's family would like to order Pasteurized Donor Human Milk (PDHM) from Mothers' Milk Bank Northeast. We need verification **of medical necessity** and a **request form** from you in order to process their application for financial assistance. Babies are only eligible for this program when they are medically unable to safely utilize anything other than human milk and their own parent is unable to provide this. Medical conditions in this category include congenital heart disease, abdominal wall defects, organ transplantation, necrotizing enterocolitis or hypoglycemia.

Donor milk is only available through this program for 4 weeks, is typically for the newborn population, and eligible families receive up to 10 100ml bottles per week. Please keep this in mind when developing a nutrition plan for your patient.

**Physician, please fill out the following:**

- Date of birth _____
- Gestational 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 donor milk _____

Please complete the **medical necessity form** and **request for PDHM form** ar
or scan and email to cares@milkbankne.org. **Questions?** Call 617-340-3497 d

**TO BE COMPLETED BY HEALTHCARE PROVIDER & THEN FAXED TO MOTHERS'MILK BANK NORTHEAST**

## REQUEST FOR PASTEURIZED DONOR HUMAN MILK (PDHM)

Healthcare Providers: You may use your own form if you prefer. Fax completed form to 617-527-1005.

| Baby's Name: | DOB: | Today's Date: |
|---|---|---|

**Please provide _____ (# of 100 ml bottles, typically 10 max) PDHM for** _____ weeks (up to 4 weeks)

☐ abdominal wall defects ☐ hypoglycemia ☐ congenital heart disease
☐ organ transplantation ☐ necrotizing enterocolitis ☐ other

Provide details here: _____
_____
_____
_____

## Healthcare Provider

Signature: _____

Name: _____

NPI#_____

Phone number: _____

Practice Name or Hospital: _____

Address: _____

*ns, contact Director of Hospital Relations,*

## Parents/Guardians

Name: _____

Address: _____

Phone: _____

Email: _____