

Anatomical Gift Transplantation Fund Grant Application Instructions

Purpose:

The purpose of the Anatomical Gift Transplantation Fund (AGTF) grant is to provide financial assistance for the **reimbursement** of *out-of-pocket costs incurred by the patient and not available from any other third-party payer.*

Eligibility Requirements: Eligible applicants shall be transplant recipients or donors, transplant candidates, or a transplant recipient's or transplant candidate's legal representative.

Supporting Documentation:

Grant applications shall include supporting documentation provided by a hospital that performs transplants, verifying that the grant applicant requires a transplant and specifying the costs associated with the following:

1. Costs of organ transplantation procedure;
2. Costs of post-transplantation drugs or other therapy; and
3. Other transplantation costs including but not limited to food, lodging, and transportation for recipients, living donors, or an immediate family member/caretaker.

NOTE: Reimbursement requests must be supported by *original* and *itemized* receipts that clearly indicate the out-of-pocket expense. Receipts must indicate the name of the establishment, the date and time of service/purchase, and the item(s) purchased. Photocopies of receipts cannot be accepted. Receipts must be sorted by category, e.g. parking, lodging, meals & food, misc. and placed in chronological order. Small receipts must be taped to an 8 ½ x 11 piece of paper.

Receipts are not returned to the applicant. Receipts are kept with the application and forwarded to the Iowa Department of Administrative Services for the reimbursement process.

See the *Guidelines* available at http://www.idph.state.ia.us/bh/anatomical_gift.asp for information relating to eligible and ineligible expenses.

Funding Source:

The AGTF consists of funds collected by county treasurers as a contribution from the public when purchasing motor vehicle registrations. The funds are allocated as per Iowa Code Chapter 142C.15.

Available Funds

Funding is ongoing. Grant applications will be evaluated by IDPH Program Planner as received. Grant applications meeting the requirements will be awarded funding as available and appropriate.

Payments and Reporting Requirements:

Payments shall be made on a reimbursement basis on forms provided by IDPH and for out-of-pocket expenses incurred by the transplant patient or candidate, or their legal representative

Grant applications must be maintained and available for review by IDPH for five (5) years following the grant period.

These reimbursements are considered State Aid and therefore will not generate a form 1099 for taxes. However, applicants should confer with a financial advisor if any questions.

Application Format and Content:

The application must be in the format of that provided. Photocopies or exact computer-generated replicas are permissible.

Grant Application Process:

To be considered for funding, a grant application shall be completed and mailed to the following address. Questions should be directed to the contact information provided below.

Iowa Department of Public Health
Attn: Sherry Frizell
Lucas State Office Building-6th Fl., 321 East 12th Street
Des Moines, IA 50319-0075
Ph#: 515-281-4636 | Email: sherry.frizell@idph.iowa.gov

Appropriate information must be provided in Description of Short-Term Need section and sub-totals and total amount requested indicated. Applications that are incomplete will be returned to the applicant or sponsoring transplant center prior to further consideration.

The Iowa Department of Public Health reviews applications in the order they are received. Unfinished applications (sections blank, no signatures, loose cash register receipts, etc.) will be returned for completion and/or corrections.

Shaded areas are to be completed by Transplant Center staff.

For IDPH use only	
Documentation supporting reimbursement of transplantation expenses received and reviewed. Approve reimbursement for the following amount:	
\$ _____ orgn 5101	
_____	_____
Sherry L. Frizell	Date

**STATE of IOWA
ANATOMICAL GIFT TRANSPLANTATION FUND**

Grant Application

This application will be used to determine the patient's eligibility for financial grant assistance. This application must be completely filled out by the patient/parent/legal guardian and the Transplant Social Worker. Applications which are received with sections that have not been fully completed will be returned to the applicant or transplant center for completion prior to further consideration.

Print or type all information

Date Completed: _____

Shaded areas are to be completed by Transplant Center Social Worker (staff).

PATIENT INFORMATION

Patient's Name: _____

Patient's Legal Address (**must** match address shown on submitted W-9 and the state of Iowa vendor system):

Date of Birth: _____ Marital Status: _____

Telephone: _____ Email: _____

Is patient currently employed? Yes No If yes, state position: _____ and name and address of employer: _____

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Individual completing this application if not the patient (legal representative, guardian etc.):

Name: _____

Relationship: _____

Mailing Address: _____

Telephone: _____ Email: _____

TRANSPLANT PROCEDURE INFORMATION

Type of transplant: _____ Date of transplant: _____

Dates of hospital stay/s: _____

Date added to transplant list: _____ Date of release to return home: _____

Is the patient a recipient? or a donor?
If donor, is the recipient a legal resident of Iowa? Yes No

See the *Guidelines* available at http://www.idph.state.ia.us/bh/anatomical_gift.asp for information relating to eligible and ineligible expenses.

Description of Short-Term Need

A. Costs of organ transplantation procedure:

Description	Cost
_____	\$ _____
_____	\$ _____
Transplant Subtotal	\$ _____

B. Costs of post-transplantation drugs (prescriptions) or other therapy:

List medications prescribed post-transplant.

Description	Cost
_____	\$ _____
_____	\$ _____
_____	\$ _____
Rx Subtotal	\$ _____

C. List of medications prescribed pre-transplantation:

D. Other transplantation costs including but not limited to food (**itemized, original receipts required**), lodging, and transportation for recipient, living donors, or a single immediate family member/caretaker.

Description	Cost
(maximum \$98+ taxes per night) <u>Lodging</u>	\$ _____
(non-food items, e.g. gum, breath mints, candy, etc. not eligible for reimbursement) <u>Food</u>	\$ _____
(Mileage must be justified/explained. Vicinity miles are limited to 10 miles per day) <u>Mileage (39¢/mile)</u>	\$ _____
_____	\$ _____
_____	\$ _____
Other Subtotal	\$ _____

Does the patient receive insurance or other coverage related to these costs? Yes No

Type of coverage/name of provider:

_____	\$ _____
_____	\$ _____
TOTAL	\$ _____

Has coverage been exhausted and grant application is for items not covered? Yes No

NOTE: AGTF will not reimburse for expenses covered by insurance, Medicaid, Medicare, etc.

TOTAL Dollar Amount Requested \$ _____
(maximum reimbursement \$4,000)

TRANSPLANT CENTER INFORMATION, VERIFICATION AND RECOMMENDATION:

Patient's Name: _____ Known Patient Since: _____

Facility where transplant performed: _____

Health professional contact that is able to verify information provided in this application:

Name: _____ Position: _____

Address: _____

Telephone number: _____ Facsimile number: _____

Email (required): _____

Donor Organization: _____

I recommend that this patient be given favorable consideration for a grant award under this program in order to assist her/him with this short-term need: Yes No and the basis for my recommendation is as follows.

Recommendation and Comments (required). Include any clarification of information presented by the client or representative. This may include transplant procedures, costs of procedures, insurance coverage and any other information that may be of benefit in assessing the application. Include additional pages as needed.

Statement Verifying the Need for Grant Award Consideration

I have reviewed the documentation and receipts as provided by this patient and to the best of my knowledge, the information on the grant application submitted is correct and accurately reflects the patient's out-of-pocket expenses, current health and financial status:

Yes

No

Signature: _____
[Authorized Signature Required]

[Date Signed]

Submit this application to:

Iowa Department of Public Health
Attn: Sherry Frizell
Lucas State Office Building, 321 East 12th Street
Des Moines, Iowa 50319-0075