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 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 include the name of the establishment, the date and time of service/purchase, and the item(s) purchased. Photocopies of receipts will not be accepted. Receipts must be sorted by category, e.g. parking, lodging, meals & food, misc. and placed in chronological order. Small receipts are to be taped to an 8 ½ x 11 piece of paper (one side only. Do not fold or overlap receipts. Large/long receipts may be folded and affixed to the other side of the 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. The information there is subject to change without notice.

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 and Administrative Code Chapter 122 (641).

Available Funds
Funding is ongoing. Grant applications will be evaluated by the Iowa Department of Public Health (IDPH) Project Director 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: RaChel Greenwood
Lucas State Office Building-6th Fl., 321 East 12th Street
Des Moines, IA 50319-0075
Ph#: 515-218-0630 (Amanda McCurley) | Email: anatomicalgift@idph.iowa.gov

Appropriate information must be provided in the 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 applications are reviewed in the order 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
______________________________________ IDPH Staff Person 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; do not use pencil 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: ____

\+ +

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. The information located there is subject to change without notice.

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.	Cost
_____	$ _____
_____	$ _____
_____	$ _____
($2,000 maximum reimbursed) **Rx Subtotal**	$ _____

C. List of medications prescribed pre-transplantation:

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

	Cost
(prior to 8/1/2021 maximum $98+ taxes per night, after 8/1/2021 maximum $120+ taxes per night) Lodging	$ _____
(non-food items, e.g. gum, breath mints, candy, etc. not eligible for reimbursement) Food	$ _____
(Mileage must be justified/explained. Vicinity miles are limited to 10 miles per day) Mileage (39¢/mile)	$ _____
_____	$ _____
_____	$ _____
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)

Patient's Statement of Financial Need (REQUIRED):

Please provide a brief summary of the relevant details and circumstances, which have led the patient to seek outside financial assistance. Include additional pages as needed.

Acknowledgment, Release, and Certification

The undersigned hereby certifies that the information contained in the application, to the best of his/her knowledge, is complete and accurate. The undersigned acknowledges that this application will be relied upon by the Iowa Department of Public Health (IDPH) in determining whether or not to provide grant funds on behalf of the patient. The undersigned (for himself/herself and his/her successors) agrees to contact IDPH immediately upon a material change in circumstances of the patient, including, but not limited to, the death of the patient or the realization of funds from other sources by any person that would materially change the financial information in this application. The undersigned acknowledges that the goal of this program is to provide its limited resources to those patients most in need and agrees to cooperate with this goal. Therefore, the undersigned agrees to cooperate if a material change in his/her circumstances occurs. The undersigned acknowledges that any funds awarded by IDPH are subject to audit.

The undersigned agrees that IDPH shall have free access to information available from third parties reasonably necessary to confirm the accuracy of the information contained in this application. Furthermore, the undersigned directs all such third parties to cooperate fully with IDPH in such due diligence.

The undersigned hereby authorizes the physician, social worker, pharmacist, or other healthcare professionals for the patient to complete and provide a "Verification Statement" and any other relevant information to IDPH with regard to this application. The undersigned specially waives the duties of confidentiality, either expressed or implied, upon such physician, social worker, or, as applicable, any pharmacists and other healthcare providers, as necessary or appropriate to respond to and/or verify this application fully and accurately.

Signature of patient or, if appropriate, parent or legal guardian:

[Transplant Patient or Legal Representative] [Date Signed]

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.

_____

_____

_____

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_____

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: RaChel Greenwood
Lucas State Office Building, 321 East 12th Street
Des Moines, Iowa 50319-0075