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 (applicant) and not available from any other third-party payer.

**Eligibility Requirements:** Eligible applicants shall be transplant recipients or living donors, transplant candidates, or a transplant recipient’s or candidate’s legal representative. The potential recipient or donor must be a legal resident of Iowa.

**Supporting Documentation:**
Grant applications shall include supporting documentation provided by a transplant center, verifying the grant applicant required 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. **Do not tape or highlight** over information on receipts; illegible expenses will not be reimbursed.

**Receipts are not returned** to the applicant.

See the Guidelines available at [www.IowaDonorNetwork.org/agtf](http://www.IowaDonorNetwork.org/agtf) for information relating to eligible 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 are evaluated by Iowa Donor Network (IDN) as they are 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 IDN and for out-of-pocket expenses incurred by the transplant patient or candidate, or their legal representative. The maximum reimbursement for surgeries on or after 7/1/2022 is $6,000. The maximum reimbursement for surgeries prior to 7/1/2022 is $4,000.

Grant applications must be maintained and available for review by IDN 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 they have 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 along with receipts to the following address.

Iowa Donor Network
ATTN: Anatomical Gift Program
550 Madison Ave
North Liberty, Iowa 52317

Appropriate information must be provided in the Description of Short-Term Need section and subtotals 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.

For questions or additional information about the AGTF please contact:

Angie Capps, Dir. Of Inspire the Gift at Iowa Donor Network
Ph: 319-665-3787
Email: anatomicalgift@iadn.org
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 the Transplant Center Social Worker/Coordinator.

PATIENT INFORMATION

Patient’s Name:__________________________________________________________

Patient’s Legal Address:__________________________________________________

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 ☐

For IDN use only

Documentation supporting reimbursement of transplantation expenses received and reviewed. Approve reimbursement for the following amount:

$___________________________

IDN Staff Person Date

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Description of Short-Term Need

A. Costs of organ transplantation procedure:

List each procedure associated with the transplant:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

Transplant Subtotal $ _____

B. Costs of post-transplantation medications or other therapy:

List medications prescribed post-transplant:

<table>
<thead>
<tr>
<th>Medication</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
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</tbody>
</table>

($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.

<table>
<thead>
<tr>
<th>Item</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Mileage</td>
<td></td>
</tr>
<tr>
<td>Lodging</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Other Subtotal (please describe): $ _____

Other Subtotal (please describe): $ _____

Other Subtotal $ _____

* Alcohol and non-food items, e.g. gum, breath mints, candy, etc. not eligible for reimbursement

** Effective 07/01/2022: mileage reimbursement at 50¢ per mile. Prior to 07/01/2022, mileage 39¢ per mile.

*** Effective 01/01/2022: in order to be eligible for reimbursement for lodging within Iowa, the lodging must be certified as having taken the Iowa Office to Combat Human Trafficking training. See Combat Human Trafficking - Certified Lodging in Iowa. Expenses incurred at lodging not certified are not eligible for reimbursement.

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

Type of coverage/name of provider: ____________________________ $ _____

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

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

TOTAL Dollar Amount Requested $ _____

Maximum reimbursement for surgeries on or after 7/1/2022 is $6,000.

Maximum reimbursement for surgeries prior to 7/1/2022 is $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 Donor Network (IDN) 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 IDN 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 IDN are subject to audit.

The undersigned agrees that IDN 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 IDN 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 IDN 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 legal guardian: __________________________________________________________

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: __________________ Fax 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 (include the basis of your recommendation below):  Yes ☐ No ☐

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 along with receipts to:

Iowa Donor Network
ATTN: Anatomical Gift Program
550 Madison Ave
North Liberty, Iowa 52317