# 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 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**

**For IDN use only**

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

$_____

_____

IDN 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 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:_____

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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 www.IowaDonorNetwork.org/agtf for information relating to eligible and ineligible expenses. The information located there is subject to change**

**Description of Short-Term Need**

A. Costs of organ transplantation procedure:

***List each procedure associated with the transplant***

_____ $ _____

_____ $ _____

**Transplant Subtotal** $ _____

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

***List medications prescribed post-transplant.***

_____ $ _____

_____ $ _____

_____ $ _____

($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.

Food Subtotal* $_____

Mileage Subtotal** $_____

Lodging Subtotal*** $_____

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.

_____

_____

_____

_____

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_____

**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**