EAST TENNESSEE KIDNEY FOUNDATION

ETKidney.org @ETKidney P.O. Box 22072, Knoxville, TN 37933 865.288.7351(o)

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM GUIDELINES

Effective Fiscal Year July 1, 2017 - June 30, 2018

QUALIFICATION GUIDELINES *(SUBMIT APPLICATIONS ELECTRONICALLY)*

1. Applicants with TennCare are not eligible for assistance.
2. Applicants' annual income must be 250% or below the Federal Poverty Level according to household size.
3. Applicant must live in one the following 15 counties (*Applicants from outside this service area may apply, but will only be approved as funds are available.)*:

Anderson	Claiborne	Hamblen	Loudon	Scott
Blount	Cocke	Jefferson	Monroe	Sevier
Campbell	Grainger	Knox	Roane	Union

REIMBURSEMENT GUIDELINES *(SUBMIT REIMBURSEMENT FORMS ELECTRONICALLY)*

1. Private vehicle transportation: ETKF will reimburse 100% of approved applicants' monthly dialysis transportation expenses up to a maximum of $65. Private transportation will be reimbursed at the rate $0.24/mile. Monthly transportation requests should be made by multiplying the # of trips (up to 13) made to the dialysis clinic, the roundtrip distance (in miles) from patient home to clinic, and the mileage rate of $0.24/mile. Initial reimbursement request is applicant's maximum reimbursement amount.
2. Public transportation: ETKF will reimburse 100% of approved applicants' monthly dialysis transportation expenses up to a maximum of $65. Public transportation requests should be made by multiplying the # of trips made to the dialysis clinic by the amount the method of public transportation charges per round trip.

PROGRAM REQUIREMENTS ONCE APPROVED

1. Approved applications will be valid for the remainder of the East Tennessee Kidney Foundation's fiscal year, which ends June 30th of each year.
2. Applications received by the tenth (10th) of the month will be considered for approval that same month; applications received after the tenth (10th) of the month will be considered for approval the following month.
3. Lost or missing checks will be reissued after a 90 day waiting period, upon approval of the Patient Services Committee, which meets once per month.
4. The Dialysis Clinic Social Worker must reapply for patient(s) currently on the program by June 25, 2017. ***Previous approval does not guarantee approval the following year. Late submissions will be placed on a waiting list even if they were previously approved.***
5. The Dialysis Clinic Social Worker must accurately complete a monthly reimbursement form for all approved patients on the program, which must be emailed to the ETKF Patient Services Committee Chair at PatientServices@ETKidney.org *no later than the 10th of each month,* ***no exceptions.*** *Reimbursement forms submitted after the 10th will be reviewed the following month.*
6. The Dialysis Clinic Social Worker will **note any/all changes in patient status on the Monthly Reimbursement Form** (including but not limited to change in transportation [ex: temporary EMS transport], change in modality, dialysis needs [ex: transplant, change in health condition, death], change of address and county of residence, dialysis clinic and/or social worker. ***Do NOT email changes***.
7. If a patient fails to cash two (2) non-consecutive mileage reimbursement checks within a six (6) month time period, his/her social worker will be contacted by ETKF to assess the situation and reevaluate the patient's level of need. This will serve as a warning of being dropped from the program. If checks continue to go unused, the patient will be dropped from the program. All attempts will be made to keep a patient on the program if he/she is in need of assistance. **Kindly remind your patients to cash their checks ASAP.**

8. *Funding for this program comes from multiple sources, including United Way agencies. A requirement of receiving UW funding is providing a* ***"Success Story"*** *about how funding has helped our patients. Submit a brief "Success Story" for one patient in each of the counties in which your patients on this program reside.* ***Your contribution to the continued funding of this program is vital and greatly appreciated! Thank you!***

EMAIL All Applications, Reimbursement Forms & "Success Stories" to PatientServices@ETKidney.org
(or ETKF, fax # 865.674.5012)

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DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM APPLICATION

Effective Fiscal Year July 1, 2017 - June 30, 2018

Applicant Information: Today's Date:_____/_____/_____

Name (First) _____(MI)_____(Last)_____

Street Address:_____

City: _____ State: _____ ZIP: _____ COUNTY:_____

Date of Birth:____/_____/_____ Gender: M ◯ F ◯ Phone:(___)_____ # in Household:_____

Household Income (work, SS, retirement, food stamps, etc.): *Annual* $_____ *Monthly* $_____

Does Applicant have TennCare? YES ◯ NO ◯
(**Applicants with transportation benefits through TennCare do not qualify.)*

Distance from Applicant Household to Dialysis Clinic (roundtrip):_____(miles)

Method of Transportation:

Private Vehicle: ◯	$0.24 x Total Roundtrip Distance (miles) = Cost ->	Cost per Round Trip: $_____
ETHRA: ◯	_____	Cost per Round Trip: $_____
KAT (Bus *or* Lift) ◯	_____	Cost per Round Trip: $_____
CAC ◯	_____	Cost per Round Trip: $_____
Other: ◯	_____	Cost per Round Trip: $_____

Survey Question for Applicant (responses are confidential & for grant/statistical purposes only):

1. The goal of ETKF's Dialysis Transportation Program is to make a positive impact in the lives of our patients. Have you had to sacrifice basic needs such as medications, nutrition (groceries & healthy foods), utilities, mortgage / rent, etc. in order to afford transportation to dialysis? YES ◯ NO ◉
2. If approved, how will this funding help to alleviate these financial dilemmas?_____

_____

Dialysis Clinic Information:

Company Name/Location:_____

Street Address:_____

City: _____ State: _____ ZIP: _____ COUNTY:_____

Clinic Phone: (_____)_____ Fax: (_____)_____

Dialysis Clinic Social Worker:_____

To our full knowledge and belief, the information provided above is complete and accurate. We understand all program guidelines and that not adhering to the guidelines may result in patient's removal from the program.

_____ _____
(Applicant/Patient Signature) *Handwritten Signature ONLY* (Signature Date)

_____ _____
(Dialysis Clinic Social Worker Signature) *Handwritten OR Electronic Signature* (Signature Date)

EMAIL All Applications, Reimbursement Forms & "Success Stories" to PatientServices@ETKidney.org
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DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM
MONTHLY REIMBURSEMENT FORM

Effective Fiscal Year July 1, 2017 - June 30, 2018

Change in Patient Status? NO ◉ YES ○ If yes, note change(s) here:_____

Changes include, but not limited to, change in transportation [ex: temporary EMS transport], change in modality, dialysis needs [ex: transplant, change in health condition, death], change of address and county of residence, dialysis clinic and/or social worker.* ***Do not email changes**; please note any above.*

Reimbursement for Month of: January, Year: 2017

Patient Information:

Name (First) _____(MI)_____(Last)_____

Street Address:_____

City: _____ State: _____ ZIP: _____ COUNTY:_____

Reimbursement Information:

Private Car:
# of Trips to Clinic_____ x Roundtrip Miles to Clinic_____ x $0.24/mile = Actual Expense $_____
(Max $65)

-OR-

Public Transportation: (Circle One: ETHRA, KAT Bus, KAT Lift, CAC, Other:_____)

# of Trips to Clinic _____ x Cost Per Round Trip $ _____ = Actual Expense $ _____
(Max $65)

Dialysis Clinic Information:

Company/Location:_____

Street Address:_____

City: _____ State: _____ ZIP: _____

Clinic Phone: (_____)_____ Fax: (_____)_____

Dialysis Clinic Social Worker:_____

To my full knowledge and belief, the information provided above is complete and accurate. I understand that my providing anonymous "Success Stories" greatly improves grant funding opportunities for this program. Patient names/photos are a bonus; donors love to see and hear about the people in whose lives their donations make a difference. ***Names/photos will ONLY be used if patient provides written consent via ETKF media release.***

_____ _____
(Dialysis Clinic Social Worker Signature) (Signature Date)

EMAIL All Applications, Reimbursement Forms & "Success Stories" to PatientServices@ETKidney.org
(or ETKF, fax # 865.674.5012)

EAST TENNESSEE KIDNEY FOUNDATION

CONSENT FOR PUBLICATION

I, the undersigned, do hereby give consent for my contribution to be published by the East Tennessee Kidney Foundation, and release to the East Tennessee Kidney Foundation all rights of any kind to the materials in which they are published. This is a full release of all claims whatsoever I or my heirs, executors, administrators or assigns now or hereafter have against the East Tennessee Kidney Foundation, or its employees or Board of Directors, as regards to any use that may be made by them of said publications.

Further, I acknowledge that my name and biographical material, portrait, picture, likeness, or voice may be used for purposes consistent with East Tennessee Kidney Foundation's mission of providing assistance to local patients suffering from kidney disease, engaging the public in education about kidney disease detection, prevention, and improvement of health and well-being of individuals affected by these diseases, and increasing the availability of all organs for transplant, including the promotion and publicizing of the materials in which I am published. Such uses as may be made will not constitute a direct endorsement by me of any product or service.

Published material shall refer to, not only printed material, but also other media as well, including emails, and the internet.

I have read this entire document, understand the contents and have willingly agreed to the above conditions by indicating with my signature below.

1) Please sign and date below to give the East Tennessee Kidney Foundation consent to publish, as stated above.

_____ _____

Printed Name Date

_____ _____

Signature Date

Email (optional): _____

☐ Check here if you would like to receive the ETKF informational e-newsletter, via the email listed above (if checked, make sure you include your email address on the line above).