EAST TENNESSEE KIDNEY FOUNDATION

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

PROGRAM PACKET

Effective July 1, 2022 - June 30, 2023

Saving & Improving the Lives of Individual East Tennesseans

Established in 2011 by Dianne Hagey, LCSW,
ETKF Board of Directors and Patient Services Committee Volunteers

Revised July 2022

Documentation of ETKF's HIPAA compliance with online 'G Suite' services shall be provided upon request.
Contact ETKF for questions or clarifications: email PatientServices@ETKidney.org or call the office 865-288-7351.

EAST TENNESSEE KIDNEY FOUNDATION

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

Effective **July 1, 2022 - June 30, 2023**

PROGRAM ELIGIBILITY

1. Applicants with TennCare are **not** eligible.
2. Applicants **must reside** within one of the following counties:

Counties Served				
Anderson	Cocke	Hancock	Loudon	Sevier
Blount	Cumberland	Hawkins	Monroe	Sullivan
Campbell	Grainger	Jefferson	Morgan	Unicoi
Carter	Greene	Johnson	Roane	Union
Claiborne	Hamblen	Knox	Scott	Washington

3. Applicants' annual incomes must be **at or below 250%** of 2022 Federal Poverty Levels according to household size. This threshold is **indicated in the chart below,** highlighted in red/yellow:

2022	Federal Poverty Levels (for the 48 Contiguous States; excludes HI & AK)			2022	
Household Size	**100%**	**150%**	**200%**	**250%**	**300%**
1	$13,590	$20,385	$27,180	$33,975	$101,925
2	$18,310	$27,465	$36,620	$45,775	$137,325
3	$23,030	$34,545	$46,060	$57,575	$172,725
4	$27,750	$41,625	$55,500	$69,375	$208,125
5	$32,470	$48,705	$64,940	$81,175	$243,525
6	$37,190	$55,785	$74,380	$92,975	$278,925
7	$41,910	$62,865	$83,820	$104,775	$314,325
8	$46,630	$69,945	$93,260	$116,575	$349,725

**for Households with more than 8 persons, add $4,720 for each additional person*
Source: US Dept. Health & Human Services, July 2022

GUIDELINES for APPROVED PATIENTS

- Approved patients are eligible for transportation reimbursement each month through June 30, 2023.
- Reimbursement reports must be submitted by the tenth (10th) of each month in order to be reviewed at that month's patient services committee meeting; reports received after the tenth (10th) will be reimbursed with the following month's checks.
- LOST checks:
  - Lost checks reported by *patients* will be reissued after a 90-day waiting period.
  - Lost checks reported by *social workers* will be reissued after a 30-day waiting period, and/or upon approval of the Patient Services Committee.

Documentation of ETKF's HIPAA compliance with online 'G Suite' services shall be provided upon request.
Contact ETKF for questions or clarifications: email PatientServices@ETKidney.org or call the office 865-288-7351.

EAST TENNESSEE KIDNEY FOUNDATION

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

Effective **July 1, 2022 - June 30, 2023**

APPLICATION INSTRUCTIONS

- **Step 1**: Complete an **online** application.
  - APPLICATION LINK: **https://forms.gle/x9tbeX8dwtB7KFX8A**
    - Answer the application questions on the online form. Click Next. Click "Finish" on the last page to submit the final application. You will receive a confirmation email.
    - **NOTE** on How to **CALCULATE** the **AVERAGE** Monthly Cost of Transportation
      - Do NOT cap this amount. We want the FULL COST of monthly travel. Calculate the monthly travel costs using below formulas. Enter the answer in this section of application.
      - **Private vehicle** = (Roundtrip mileage to/from clinic/home) x (ave. # monthly trips) x (rate of $0.30/mile).
      - **Public transportation** = (ave.trips/month=13) x (cost for roundtrip service for 1 visit).
        - ETHRA is $6 per roundtrip.
        - CAC is $4 roundtrip.
        - KAT Bus is $2 roundtrip.
        - KAT LIFT is $4 roundtrip.
      - Average # of monthly trips to/from dialysis clinic per modality:
        - In-center hemodialysis (ICHD): 13 trips / month
        - Home hemodialysis (HHD): 1-2 trips / month
        - Peritoneal (PD): 2-3 trips / month
        - Use correct visit #'s for each patient according to their modality & individual tx plan.
      - Note that amounts will vary per client. Each client's maximum monthly approved amount will be provided in monthly approval emails.

- **Step 2**: Print Consent Form (2 pages included in this packet). Review this form with patient; obtain patient initials & signature. Sign & date.

- **Step 3**: Email a completed Consent Form (2 pages), copy(ies) of all insurance card(s) and a face sheet with each application to patientservices@etkidney.org.

- **Applications are always DUE by the 10th of each MONTH!** Applications may be submitted at any time. *However*, applications received by the tenth (10th) of each month will be reviewed at that month's patient services committee meeting; applications received after the tenth (10th) will be not be reviewed until the following month's meeting.
- *Example of Deadlines & Notification Timelines:* You submitted an application for John Doe on August 10. You will know if he is approved or not by the end of August. *You submitted an application the next day, August 11, for Jane Doe. You will not know if she is approved or not until the end of September.*

COLLABORATION

- We need YOUR HELP to grow this program through grants and donations**.** Donors NEED to see how the money they donate to us makes a real impact. Pictures are so helpful! Please let your patients know when reviewing the "Share Your Story" Section of the Consent Form that the terms "client" & "patient" are impersonal. Encourage them to share with the community the REAL PEOPLE who are being helped by this program. Their personal stories of struggles & accomplishments are heartwarming & inspirational! Photos are wonderful to share!

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

Effective **July 1, 2022 - June 30, 2023**

REIMBURSEMENT REPORT INSTRUCTIONS

- **Step 1**: Complete an **online** reimbursement report. **DUE by the 10th of each MONTH!**
  - REIMBURSEMENT REPORT LINK: **https://forms.gle/4HWB4dbBsxSf5ond8.**
    - Answer the report questions on the online form. Click Next. Click "Finish" on the last page to submit the final application. You will receive a confirmation email.
    - Report any & all changes in patient status via the Patient Changes Section. If a patient does not need reimbursement during a certain month, still complete a report for that person and indicate why that monthly request is $0. *Do NOT email us changes except to stop/shred a check.*
    - **NOTE** on How to C**ALCULATE** the **ACTUAL** Cost of Transportation for Each Month
    - Use the formulas in Step 1 of the Application Instructions to calculate each patient's monthly request. *However…*
    - Use the ACTUAL # of ATTENDED treatments for the month you are reporting, NOT the AVERAGE used in the application calculation.
    - Do not enter an amount higher than each patient's maximum monthly approved amount.
    - Note that amounts will vary per client. Each client's maximum monthly approved amount will be provided in monthly approval emails.
    - Report MEASURABLE RESULTS by answering the questions honestly. These questions are **NOT busy work**! We are mandated by GRANTORS to collect QUALITATIVE, MEASURABLE DATA to evaluate program success. There are no wrong answers. It is okay to say that the program is not working for your patient(s). We need your honest feedback!

- **Step 2**: Check your inbox for your confirmation email. If you do not see it within a few minutes of submitting the report, check your spam / junk folders. Often large companies have filters in place for electronic security.

- **Step 3**: At the end of the month, you will receive your patients' checks in the mail from ETKF. If you do not have a mailbox at your clinic, inform all (& any front desk) staff that you will be expecting an important envelope from ETKF at the end of each month. Distribute the checks to your patients. It is recommended that you document when you give your patients the checks, for future reference regarding patient inquiries.

ONGOING COLLABORATION

- As mentioned in the application instructions, PLEASE send us a brief "Success Story" of a patient who is / has been improving since joining our program. You may change the name & any other identifying information if the patient prefers. Of course, photos and real names are always the best & lovely to share!! We need your help to grow this program through grants and donations**.** United Ways and donors need to see that their grants & donations are making a real difference. Pictures are wonderful additions too!

- Kindly remind your patients to cash their checks ASAP. If a patient fails to cash two (2) mileage reimbursement checks within a six (6) month time period, the social worker will be contacted to assess & reevaluate the patient's level of need. This will serve as a warning of being removed from the program. If checks continue to go unused, the patient will be removed from the program. All attempts will be made to keep a patient on the program, and to provide assistance if depositing/cashing checks is a hardship.

EAST TENNESSEE KIDNEY FOUNDATION

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

Effective **July 1, 2022 - June 30, 2023**

APPLICANT CONSENT FORM

To be completed by the applicant/dialysis patient. Submit this form (2 pages total) with application.

Applicant Name:____ Applicant DOB ____/_____/______

The patient should read / listen to each section below carefully. If patient consents, s/he should INITIAL the "I CONSENT" line; if patient does not consent, s/he should INITIAL on the "I DO NOT CONSENT" line. Only one line should be initialed for each question.

Electronic Signature

I acknowledge and give my consent for my dialysis clinic social worker (and/or dialysis clinic representative) to complete all and any necessary paperwork required by the East Tennessee Kidney Foundation, Inc.™ and its programs, including but not limited to program applications, monthly reimbursement request forms, treatment sheets, insurance information and applications for additional programs for which I may qualify for assistance. I give consent and authorize my dialysis clinic social worker (and/or dialysis clinic representative) to provide my "Electronic Signature" on any and all forms and documents which must be submitted online. I understand and agree that my "Electronic Signature" carries the same legal weight and meaning as my signature on a paper document.

_________I CONSENT ________I DO NOT CONSENT

Communication

I acknowledge and give my consent for my dialysis clinic social worker and/or dialysis clinic representative (i.e. physician, social worker, dietitian, nurse, renal health professional) to share information about my renal health and other confidential information such as insurance coverage, demographics, lab values, dialysis treatment attendance, transportation method and activity, among other information with the East Tennessee Kidney Foundation, Inc.™ and their representatives as it relates to my participation in their programs.

_________I CONSENT ________I DO NOT CONSENT

Application & Program Guidelines

To my full knowledge and belief, my social worker and I have discussed the questions and answers on this program application and we have provided correct and accurate information. I understand all program guidelines and that not adhering to said guidelines including reporting of any false data whatsoever may result in my removal from the program. I understand the program guidelines include depositing or cashing my assistance checks as soon as possible, and that not doing so may be grounds for removal from the program.

_________I CONSENT ________I DO NOT CONSENT

Email

List your email address if you wish to receive periodic email updates from the East Tennessee Kidney Foundation, Inc.™

_________I CONSENT** ________I DO NOT CONSENT

***If you consent, provide your email address:*____

EAST TENNESSEE KIDNEY FOUNDATION

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

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

Effective **July 1, 2022 - June 30, 2023**

APPLICANT CONSENT FORM, cont'd.
SHARE YOUR STORY

To be completed by the applicant/dialysis patient. Submit this form (2 pages total) with application.

Photo / Media Release

I understand that sharing my story, which may or may not include an informal photograph, is one of the ways the East Tennessee Kidney Foundation, Inc.™ communicates the struggle dialysis patients go through every day, and how important it is to take care of our renal community. I understand and provide my consent to sharing my name and brief biographical material, image, picture, video, likeness, or voice for the sole purposes consistent with the East Tennessee Kidney Foundation Inc.™'s mission of serving individual East Tennesseans suffering from kidney disease.

I hereby provide my consent and authorize the publicizing and sharing of my image whether it be in printed publications such as brochures and pamphlets, online media platforms, grant applications and "success stories" reports sent to grant makers, newsletters, cards and/or other respectful means appropriate to the mission the East Tennessee Kidney Foundation, Inc.™. I do hereby release to the East Tennessee Kidney Foundation, Inc.™ all rights of any kind to the materials in which my image or likeness 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, Inc.™ or its employees or Board of Directors, as regards to any use that may be made by them of said publications. I understand that I can withdraw my consent at any time simply by notifying my social worker and completing a new consent form.

1. "Success Story" with Name Changed for Privacy: ________I CONSENT _______I DO NOT CONSENT
2. "Success Story" with Real Name & Photo.........: ________I CONSENT _______I DO NOT CONSENT

Photo Submission
Please share a "selfie," or other appropriate photo of either patient only, or with family, friends, or pets! Social workers, please email the picture to patientservices@etkidney.org, or patients can bring in a physical picture for you to mail to ETKF, P.O. Box 22072, Knoxville, TN 37933.

---

*Applicant Signature:____

*Applicant Name (Print):______________________________Date_____/_____/_____

Social Worker Signature:____

Social Worker Name (Print):____________________________Date_____/_____/_____

Documentation of ETKF's HIPAA compliance with online 'G Suite' services shall be provided upon request.
Contact ETKF for questions or clarifications: email PatientServices@ETKidney.org or call the office 865-288-7351.