



EAST TENNESSEE KIDNEY FOUNDATION

ETKidney.org

@ETKidney

P.O. Box 22072, Knoxville, TN 37933

865.288.7351

DIANNE HAGEY DIALYSIS TRANSPORTATION PROGRAM

PROGRAM PACKET

Effective July 1, 2023 - June 30, 2024



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 May 2023

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.



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PROGRAM ELIGIBILITY

There are only 3 eligibility requirements for this program:

1. Applicants must not have any other insurance or resource that pays for transportation. Applicants with TennCare are **not** be eligible; however, some applicants with QMB only **may** qualify. Call to inquire if your applicant has transportation coverage or not, and the details, before applying for this program.
2. Applicants must **reside** in one of the following counties:

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 household incomes must be **at or below 250%** of the current year's Federal Poverty Level, according to household size. This threshold is indicated in the chart below, highlighted in yellow.

2023 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)				
Per Year				
Household/ Family Size	50%	75%	100%	250%
1	\$7,290	\$10,935	\$14,580	\$36,450
2	\$9,860	\$14,790	\$19,720	\$49,300
3	\$12,430	\$18,645	\$24,860	\$62,150
4	\$15,000	\$22,500	\$30,000	\$75,000
5	\$17,570	\$26,355	\$35,140	\$87,850
6	\$20,140	\$30,210	\$40,280	\$100,700
7	\$22,710	\$34,065	\$45,420	\$113,550
8	\$25,280	\$37,920	\$50,560	\$126,400

For families/households with more than 8 persons, add \$5,140 for each additional person.

Source: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>



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APPLICATION INSTRUCTIONS

There are **2 steps to submitting a complete application**. Step 1 is completing the online application. Step 2 is emailing all support documents to patientservices@etkidney.org. Applications are considered INCOMPLETE until ALL items have been submitted correctly & by the respective due dates.

Applications may be submitted at any time. **Complete applications are DUE by the 10th of each MONTH.**

- **STEP 1:** Complete an **online** application via this LINK: <https://forms.gle/N1ByaCjqtoEEyeTr7>.
 - Answer all questions honestly & accurately. Click "Finish" on the last page to submit final application. You will receive a confirmation email upon submission. You can edit the application at any time via the link in the email.
 - **What is the AVERAGE # of monthly trips?** Use the following as a guideline to determine a patient's average # of monthly trips, according to that patient's modality & personal treatment plan.
 - In-center hemodialysis (**ICHD**): 13 trips / month (can sometimes be 12 or 14). Use the average of 13.
 - Home hemodialysis (**HHD**): 1-2 trips / month
 - Peritoneal (**PD**): 2-3 trips / month
 - **How to CALCULATE the AVERAGE Monthly Cost of Transportation**
 - Use "**Google Maps**" (<https://www.google.com/maps>) to calculate ROUNDTRIP mileage to/from client's clinic/home. Enter the full cost of monthly travel; do NOT cap this amount. Calculate using these formulas:
 - **Private vehicle** = (Client's roundtrip mileage to/from clinic/home) x (Client's average # monthly trips) x (rate of \$0.30/mile). If you live 15 miles from the clinic, and use private vehicle, the formula would be $30 \times 13 \times 0.30 = \$117/\text{month}$ for average monthly cost of transportation.
 - **Public transportation** = (Client's average # monthly trips) x (cost for roundtrip service for 1 visit).
 - ETHRA \$6 per roundtrip. How to calculate: (ave. # monthly trips) x \$6
 - CAC \$4 roundtrip. How to calculate: (ave. # monthly trips) x \$4
 - KAT Bus \$2 roundtrip. How to calculate: (ave. # monthly trips) x \$6
 - KAT LIFT \$4 roundtrip. How to calculate: (ave. # monthly trips) x \$6
 - NET TRANS based on ZONES, via link: <https://www.nettrans.org/ride/fares/>. How to calculate: (ave. # monthly trips) x (Roundtrip fare based on zone)
 - Note that amounts will vary per client. Each client's maximum monthly approved amount will be provided in monthly approval emails.
 - **STEP 2:** Email required Support Documents to patientservices@etkidney.org. Required support documents include:
 - Consent Form,
 - Media Release,
 - Face Sheet, and
 - copies of all Insurance Cards (front & back).



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PROGRAM POLICIES for APPROVED PATIENTS

POLICIES

- You must submit a reimbursement report (online) for all approved patients, due by the 10th of each month.
- Approved patients are eligible for transportation reimbursement each month through June 30, 2024. At the end of each fiscal year (June 30) new applications must be submitted for ALL patients wanting to stay on the program for the next fiscal year.
- 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.
- 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.
- 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.

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!
- 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!
- Please send pictures and success stories to: patientservices@etkidney.org



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REIMBURSEMENT REPORT INSTRUCTIONS

- **Step 1:** Complete an **online** reimbursement report via this link: <https://forms.gle/n1JgrN1KHCqmJKTB9>.
 - Answer the report questions on the online form. Click Next. Click "Finish" on the last page to submit the final reimbursement report. 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 CALCULATE 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.
 - **EXCEPTION:** The total AVAILABLE monthly trips is sometimes 14. If the patient makes all 14 trips in those months, put 14 in the NUMBER OF ATTENDED TREATMENTS THIS MONTH section and the correct amount in the THIS MONTH'S REQUESTED AMOUNT section.
 - August 2023 (T, Th, Sat) - 14 trips available
 - January 2024 (M, W, F) - 14 trips available
 - May 2024 (M, W, F) - 14 trips available
 - Note that amounts will vary per client. Each client's maximum monthly approved amount will be provided in the client's approval email.
 - **Report MEASURABLE RESULTS** by answering the questions honestly. We are required 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. You can edit your responses at any time via the link in the confirmation email.
- You must submit a completed reimbursement report for all your clients, even if someone passes away. You can indicate the changes in the "Change in Patient Status" box. Completed Reimbursement Reports are always **DUE by the 10th of each MONTH!**
- 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 their checks**, for future reference regarding patient inquiries.



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CONSENT FORM

Print this page, complete alongside applicant & obtain signatures. Scan & email this form (2 pages total) to patientservices@etkidney.org, AFTER completing the online application. Note: applications are INCOMPLETE until all components are submitted.

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: _____



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PHOTO / MEDIA RELEASE

Print this page, complete alongside applicant & obtain signatures. Scan & email this form (2 pages total) to patientservices@etkidney.org, AFTER completing the online application. Note: applications are INCOMPLETE until all components are submitted.

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 ____ / ____ / ____



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FREQUENTLY ASKED QUESTIONS

Q: I applied for my patient weeks ago. Why haven't I heard anything yet?

*A: **Complete 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.)

Q: Why do I have to calculate the request each month? Isn't the maximum reimbursement amount the amount the patient gets each month?

*A: The maximum reimbursement amount is if the patient attended all treatments in that month. If a patient missed a treatment, then the reimbursement amount should be less to reflect that missed treatment. We are reimbursing what they **already spent**, not giving one amount every month.*

Q: My checks haven't arrived in the mail yet / my patient lost her check. Can you send replacements?

*A: Refer to the **LOST Checks Policy**:*

- 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.*

Q: My patient passed away. Can you write his last check out to his spouse?

A: Yes! Indicate to whom the check should be written and the address in the "Notes" section of the Reimbursement Report.

Q: Do I have to get copies of all insurance cards? Where do I send the consent form & media release?

A: Yes. Email all supporting documentation to patientservices@etkidney.org.

Q: Do I have to submit another application for the new fiscal year for a patient who was just approved in May?

*A: Yes. Every patient must have a new application **AND** supporting documentation on file at the beginning of each fiscal year regardless of original date of approval.*