Missouri Kidney Program
University of Missouri

Facility Guidelines Manual

This *MoKP Facility Guidelines Manual* sets forth the Missouri Kidney Program (MoKP) policies and procedures, approved by the MoKP Advisory Council and staff, which govern the end-stage renal disease (ESRD) programs and assistance administered by the University of Missouri-Columbia School of Medicine.

Requests, Suggestions and Comments may be addressed to:

Missouri Kidney Program
2800 Maguire Blvd, B110
Columbia, MO 65211

Local: 573.882.2506
Toll Free: 800.733.7345
Fax: 573.882.0167

Email: UMHSmokpinfo@health.missouri.edu
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The manual is available online. We encourage you to bookmark and share this site with your staff and colleagues for future reference.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Table of Contents

1. General and Administration Information
1:010 Program Statement
1:020 Facility Agreement
1:030 Monthly Voucher Process
1:040 Audit/Fiscal Reviews

2. Eligibility Criteria
2:010 Residence and Citizenship
2:020 MO HealthNet Requirements
2:030 Other Requirements
2:035 MoKP Income/Assets Eligibility Chart
2:040 Assistance Periods

3. Application for MoKP Assistance
3:010 Application Process Overview
3:020 Assistance Periods/Annual Renewal Process
3:030 Participant Application

4. Patient Assistance through Facility Reimbursement
4:010 Overview statement
4:020 Transportation Reimbursement
4:030 Private Premium Reimbursement

5. Centralized Drug Program (CDP)
5:010 CDP Overview
5:020 CDP Formulary
5:030 Payer of Last Resort

6. Transplant Assistance Reimbursement
6:010 Transplant Assistance
6:020 Example Letters

7. Forms and Examples
7:010 Forms
7:020 Facility Agreement – Example
7:030 Voucher by Patient Listing – Example
7:040 Application Renewal Form – Example

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 1 **General and Administrative Information**	**Section 010** **Program Statement**

MISSION

The Missouri Kidney Program (MoKP) is a state funded program administered by the University of Missouri, School of Medicine, which provides financial assistance for eligible Missourians who have kidney failure and are on dialysis, or have received a kidney transplant. The program supports education and research, partners with dialysis centers and transplant centers statewide, and has expertise in health insurance for kidney disease, including Medicaid and Medicare.

GOALS

- Maintaining low administrative costs
- Expanding service to Missourians in greatest need
- Supporting educational experiences for CKD patients and providers
- Working with organizations committed to the prevention and treatment of kidney disease
- Striving for health literate communications

ACCESS TO THE MOKP DATABASE

Access to the MoKP Database will be provided to social workers and facility billers when requested. To make this request, please call or MoKP offices directly. A brief orientation can be provided on request. Access is limited to social workers and facility billers to keep participant information secure. The MoKP database can only be accessed with an USERID and password.

PAYER OF LAST RESORT

MoKP is a payer of last resort. When other assistance or coverage is available, those sources must be investigated and applied for. MoKP requires all applicants and current participants to apply for and maintain Medicare, MO HealthNet, Medicare Supplement programs (Medigap), and/or private/group insurance (including spousal employment) as applicable. In cases where an applicant is not eligible for Medicare and a Medicare supplement, Medicaid and/or does not have access to employer group health insurance, the applicant should apply for the ACA/Marketplace plan in their area.

Note: MoKP approval for any financial assistance is always contingent on continued availability of funds to MoKP.

Chapter 1 **General and Administrative Information**	**Section 020** **Facility Agreement**

The Agreement between MoKP, through the Curators of the University of Missouri (a public corporation), and a participating facility, authorizes MoKP to reimburse for a stated purpose, for a specific period of time (July 1 through June 30 fiscal year) for pre-approved direct cost.

The Agreement (and any amendment) must be signed by an authorized individual from each facility. This Agreement states, in part, that:

- The University may terminate this agreement or require the reduction in the extent of services contracted to match the available funds.
- University and Missouri state auditors shall have access to all records pertaining to this agreement for audit or examination. Any audit exception is the sole responsibility of the contractor and shall be refunded as necessary by contractor after all legal and administrative remedies have been exhausted.
- Contractor agrees to furnish financial and final reports in compliance with MoKP requests, schedules and deadlines.
- Eligible Missouri residents will not be denied MoKP assistance under the Agreement due to the inability to pay in advance for said assistance.
- Either party may cancel the Agreement by giving a 30-day advance written notice.

Refer to Chapter 7 Forms and Examples; Section 020 to review a Facility Agreement - Example.

Chapter 1 **General and Administrative Information**	Section 030 **Monthly Voucher Process**

Facilities are reimbursed on a monthly basis for pre-approved expenditures incurred by MoKP participants. This process generally occurs the third Thursday of each month. The process is initiated by closing the facility access to the online billing system. Expenditures requested through the online billing system will be processed and a check generated the following Tuesday.

The Voucher by Patient Listing provides the facility with a list of specific patients for whom reimbursement was requested and reimbursed. The Voucher by Patient Listing is available through MoKP database.

INSTRUCTION ON HOW TO PRINT VOUCHER BY PATIENT LISTING:
You must have a USERID and password to access the Missouri Kidney Program database. Please see Chapter 1 General and Administrative Information; Section 010 on how to gain access to the Missouri Kidney Program Database.

Once in the MoKP Database, go to MoKP Reports, click on Voucher by Patient Listing located under Monthly Voucher Processing Reports. Select the desired facility.

This report is only available after the monthly voucher process has been finished and only until the database closes for the next monthly voucher process.

Refer to Chapter 7 Forms and Examples; Section 030 to review a Voucher by Patient Listing - Example.

Chapter 1 **General and Administration Information**	Section 040 **Audit/Fiscal Reviews**

MoKP reserves the right to perform facility audits to ensure reimbursements are compliant. A facility's failure to furnish, reveal and retain adequate documentation for services billed to MoKP may result in the recovery of the payments for those services not adequately documented and may result in termination.

The facility may be contacted by MoKP during the contract period to ensure that expenditures and records are in accordance with the contract guidelines.

For any refunds due MoKP as a result of an audit, the facility will have the opportunity to accept the findings or submit documentation showing why a refund should not be assessed.

All records must be retained at the facility for five years.

University and Missouri state auditors shall have access to all records pertaining to MoKP billings. All MoKP billings and/or reimbursements are subject to audit by University of Missouri-Columbia and MO state auditors.

Chapter 2	**Section 010**
Eligibility Criteria	**Residence and Citizenship**

To qualify for MoKP assistance, individuals must meet residence and citizenship requirements.

RESIDENCE AND CITIZENSHIP:
To qualify for assistance through the MoKP, an individual must be:

- A resident of the State of Missouri as defined by the Department of Social Services AND
- United States citizen or
- Alien in lawful permanent resident (LPR) status with five years of residency

Alien status requirements for MO HealthNet can be viewed in the Missouri Department of Social Services – Family Support Division – Income Maintenance Manual – Dec 73 Requirements – Section 1015.000.00 and will serve as a guideline regarding questions related to eligibility for MoKP assistance. You may review the requirements in their entirety at https://dss.mo.gov/fsd/iman/dec1973/ertoc.html

Qualified immigrants entering the U.S. on or after August 22, 1996, including Lawful Permanent Resident (LPR) are not eligible for MO HealthNet and therefore not eligible for MoKP for five years following their date of entry. Once the five-year period of ineligibility has expired, these qualified immigrants are then eligible. You may review the requirements pertaining to https://dss.mo.gov/fsd/iman/fmh/1805-000-00_1805-050-00.html

MO HealthNet's Income Maintenance Manual – Dec 73 Requirements in its entirety will serve as the final authority regarding questions of eligibility related to citizenship and/or residence. You may review the manual in its entirety at:
https://dss.mo.gov/fsd/iman/index.html

Chapter 2	Section 020
Eligibility Criteria	MO HealthNet Requirements

All MoKP applicants/participants must make application to MO HealthNet.

Fax or mail applications for MO HealthNet for Aged, Blind & Disabled (MHABD) should be sent to the Family Support Division (FSD) Eligibility Specialist located at MoKP. This will expedite the processing of the MHABD application.

Phone: 1-866-665-7373
Fax: 1-573-884-5276

MoKP FSD Eligibility Specialist
2800 Maguire Blvd, Ste B110
Columbia, MO 65211

MHABD applications are available through the MoKP database or through the Department of Social Services website.

For persons with a new diagnosis of permanent ESRD, if disability has not been established by the Social Security Administration, attaching a copy of the completed CMS Form 2728 to a MO HealthNet application and disability packet will expedite establishment of disability by the MO HealthNet Medical Review Team (MRT).

Persons who are found eligible for MO HealthNet in the form of Continuous Medicaid, SLMB1 only, SLMB2 only, QMB only, or in the form of Spend Down not exceeding $1,200/month are eligible for MoKP based on income and asset requirements.

SPEND DOWN (LIMIT):
Spend Down maximum = $1,200/month.

The following participants must also disclose household income and assets in addition to maintaining MO HealthNet benefits:

MO HealthNet Blind Pension
MO HealthNet Spend Down cases over $1,200

Persons, who are found ineligible for MO HealthNet benefits due to not meeting disability requirements and/or the participant being over the asset/resources limit, will need to provide household income and asset information to MoKP to establish eligibility based on income and asset guidelines.

Chapter 2	**Section 030**
Eligibility Criteria	**Other Requirements**

ASSET GUIDELINES:
The asset limit for MoKP assistance is $15,000 (for the household) regardless of the number of dependents. Assets are defined as liquid assets; including but not limited to savings, investments, real estate that is not attached to the property the primary residence sits on, cash surrender value of life insurance policies, retirement accounts, 401K, etc. Do not include the applicant's home, vehicles, personal possessions, burial plots or irrevocable burial contracts. NOTE: One (1) vehicle per driver in the home is allowed to be excluded in this calculation.

INCOME GUIDELINES:
For persons not eligible for MO HealthNet, eligibility will be based on the household income and assets. Please see Chapter 2 Section 035 for the MoKP Income/Assets Eligibility Chart.

MEDICAL ELIGIBILITY:
All participants must meet the following medical criteria on an ongoing basis in order to receive Missouri Kidney Program assistance:

- Stage 5 End Stage Renal Disease on dialysis; or
- Recipient of successful Kidney Transplant

MEDICARE:
All MoKP participants must have made application for Medicare Part A, and/or Part B and Part D. If approved for Medicare, the participant must maintain active coverage for Medicare Part A, and/or Part B and Part D.

MEDICARE PART D COVERAGE:
If a person has Medicare Parts A and/or B, then they are eligible to enroll in a Medicare Part D Plan. MoKP requires participants, who are receiving MoKP routine medication assistance, to enroll in a Medicare Part D Plan. At the time of application for MoKP, a consent is required to enroll the participant in a Medicare Part D Plan. The participant must complete this consent annually to remain active on the program. The consent will authorize MoKP to enroll a participant in a Medicare Part D Plan appropriate to their needs. If a premium is required for a Medicare Part D Plan, MoKP will contact the participant.

MEDICARE ADVANTAGE PLANS:
Persons enrolled in Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plans cannot receive medication assistance from MoKP.

MA/MAPD plans increase the cost for MoKP compared to Medicare Part D Plans.

Chapter 2	**Section 030**
Eligibility Criteria	**Other Requirements**

If a MoKP participant becomes enrolled in a MA/MAPD plan while receiving medication assistance, MoKP will consult with the facility social workers to provide guidance for the participant regarding the best third party payer coverage.

If other reasonable options are available and the participant chooses to stay with the MA/MAPD plan, MoKP will terminate and/or deny the application for medication assistance.

PRIVATE/GROUP MEDICAL INSURANCE
MoKP participants must maintain active coverage with any Private/Group Medical Insurance coverage that they may have at the time of MoKP application for assistance. This includes Employee Group Health Insurance, Medicare Supplements, etc. Failure to maintain insurance coverage may result in termination of assistance through MoKP. MoKP works with kidney transplant recipients receiving MoKP assistance to apply for a Medicare Supplement at the time of their 65th birthday in order to remain active with MoKP assistance.

MOKP PHARMACY USAGE
All MoKP formulary medications should be obtained through the MoKP contracted pharmacy to maintain MoKP medication assistance. The MoKP medication formulary is located through the MoKP Database or through the public website. Only controlled substances or short-term drug therapies should be obtained from a local pharmacy.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 2	Section 035
Eligibility Criteria	MoKP Income/Assets Eligibility Chart (based on 2020 FPL)

Income and asset verification is required for applicants who are:

- Not eligible for MO HealthNet
- Eligible for MO HealthNet Blind Pension
- Eligible for MO HealthNet for Children and/or Families
- Eligible for MO HealthNet Spend Down over $1,200

Routine Medications (150% of FPL)		
Dependents	**Annual**	**Monthly**
1	$19,140	$1,595
2	$25,860	$2,155
3	$32,580	$2,715
4	$39,300	$3,275
5	$46,020	$3,835
For each add'l dependent add	$6,720	$560

Private Insurance Premiums (175%FPL)		
Dependents	**Annual**	**Monthly**
1	$22,330	$1,861
2	$30,170	$2,514
3	$38,010	$3,168
4	$45,850	$3,821
5	$53,690	$4,474
For each add'l dependent add	$7,840	$653

Immunosuppressant Medications (250%FPL)		
Dependents	**Annual**	**Monthly**
1	$31,900	$2,658
2	$43,100	$3,592
3	$54,300	$4,525
4	$65,500	$5,458
5	$76,700	$6,392
For each add'l dependent add	$11,200	$933

ASSETS GUIDELINES:
Asset Limit is $15,000 regardless of the number of dependents.

Chapter 2	**Section 040**
Eligibility Criteria	**Assistance Periods**

ASSISTANCE PERIODS:

MoKP applicants are generally approved for one-year periods contingent on maintaining Medicare, third party insurances, and MO HealthNet as applicable. Annual reviews are conducted and approvals are extended in one-year increments providing MO HealthNet coverage is maintained appropriately and/or there are no significant income/asset changes.

An approval letter is sent to the participant and social worker with the dates of the participant's assistance period.

In addition to the annual review process, participant signatures will be required on certain forms annually. These forms will be sent out every June/July with notification to the social worker listed for each participant.

APPLICATION PROCESS

The Missouri Kidney Program Regional Coordinators work directly with the social workers (within contracted dialysis and transplant facilities) to complete the application process. The facility social worker is the contact person for MoKP staff.

All applications for MoKP assistance must be coordinated through the social worker. All supporting documentation must be provided for the application to be considered complete.

Phone: 1-800-733-7345
Fax: 1-573-882-0167

Mailing Address: Missouri Kidney Program
2800 Maguire Blvd, Ste B110
Columbia, MO 65211

MoKP applications may be accessed through the MoKP Database. Please refer to Chapter 1 Section 1 on how to access the database. The application is located under the Forms Menu. Examples of all application forms and documents are located in Chapter 7.

The application form consists of the following information:

1. Demographic information
2. Medicare, Mo HealthNet and other insurance information
3. Type of assistance requested, and justification for funding which <u>must</u> be signed by the social worker including both financial and socioeconomic needs.
4. Diagnosis (reason for ESRD)
5. Application Worksheet (MoKP 101) must accompany the application.
6. Participant Agreement Form (MoKP 107a) <u>must</u> be signed by the applicant.
7. If the applicant is requesting assistance with medications and/or immunosuppressants, then the following must be included with the application:
    a. Prescription Order Form—Kilgore’s Pharmacy (MoKP 103) faxed directly to Kilgore’s Pharmacy at 573-443-8253 or mailed to the MoKP address.
    b. Consent for Medicare Part D PDP Enrollment (MoKP 117)
8. If the applicant is requesting assistance with transportation, then the following must be included with the application.
    a. Transportation Worksheet (MoKP 115)
9. If MO HealthNet requirements are not met, then Income and Assets Information (MoKP 107) must be completed.

Applications will be reviewed by MoKP within the first 20 days of receipt. If the application is complete, MO HealthNet status is active, and all other requirements are met, then the applicant will receive an approval letter. If the requested information is not received, or the MO HealthNet application is not complete or is denied, the application for MoKP assistance will be terminated. Copies of the letter will be sent to the facility social worker.

Note: *Social worker will receive copies of all communications MoKP has with the participants.*

Changes in income, insurance coverage, MO HealthNet status, Medicare status, or residence must be forwarded to MoKP by the participant and/or social worker within 10 days of the change.

MoKP must be notified if the participant transfers between facilities, is hospitalized for a lengthy hospitalization, enters a rehabilitation facility, enters a nursing facility, moves out of state, or expires.

Chapter 3 Application for MoKP Assistance	Section 020 Assistance Periods/Annual Renewal Process

ASSISTANCE PERIOD
Participants are awarded approval for assistance typically for one-year periods.

AUTO RENEWAL
Active MoKP participants with one of the following categories of MoHealthNet assistance do not require an Annual Renewal Application Form to be completed, nor do they need to submit income and asset information. These participants receive a letter stating that they will be automatically renewed for another one-year contingent on there not being any changes in their financial situation. Income or MO HealthNet status changes may trigger a review to determine whether the participant continues to meet eligibility criteria.

- MHABD Continuous
- MHABD Spend Down under $1,200
- Ticket to Work Health Assurance (TWHA) Program
- SLMB or QMB

ANNUAL RENEWAL REQUIRING INCOME AND ASSET INFORMATION
Active MoKP participants without one of the categories listed above require annual evaluation of income and asset information.

Annually, the MoKP participants who do not qualify for Auto Renewal will be mailed a Renewal Application Form along with a letter containing instructions for completion. An example of the Renewal Application Form can be found in Chapter 7. These participants will be required to complete and return to MoKP the annual Renewal Application Form and the requested documents including but not limited to; current household income, current household assets, and current insurance information. Facility social workers will receive copies of correspondence sent to participants regarding the update.

NOTE: *Approval by the MoKP Coordinator for financial assistance is always contingent on continued availability of funds to MoKP.*

Chapter 3 **Application for MoKP Assistance**	**Section 030** **Participant Application**

The MoKP Participant Application is located under the Forms Menu on the MoKP Database. The Social Worker can complete the Fill and Print Application on line (or print it and complete by hand), then fax or mail to the Missouri Kidney Program.

Incomplete applications will not be processed until all requested information and documentation is received.

Instructions for how to complete the application is listed below.

PAGE ONE: Application Worksheet -- Form MoKP 101

Name = use full legal name with middle initial, no nicknames

SS# = Social Security number

Required Documentation = list of 3 documents that must be included in all applications regardless of type of assistance being requested.

1. Participant Agreement Form (MoKP Form 101) This page gives MoKP authority to handle issues that may arise with Medicare, MoHealthnet, and Private Insurance
2. Copy of the Medicare Beneficiary Identification Card and Medicare Part D Drug Plan Card
3. Copy of front and back of Commercial Insurance Card (Medicare Supplement/Medigap; Employer Group Health; Private/Personal; and/or Medicare Advantage). If policy includes prescription drug coverage, then the Notice of Creditable Coverage must also be included.

Other Documentation = documents needed for specific types of requested assistance

1. Routine medication and/or immunosuppressants
   a. Prescription Order Form (MoKP Form 103) must be faxed directly to Kilgore’s Medical Pharmacy at 573-443-4754.
   b. Consent for Medicare Part D Enrollment Form (MoKP Form 117)
   c. Kilgore's Prescription Distribution Consent Form if the applicant wishes for medications to go to an address other than home address
2. Transportation Assistance
   a. Mileage and Public Transportation Form (MoKP Form 115)
   b. Vendor Transportation Form (MoKP Form 115a)
3. Income and Assets Information Form (MOKP 107)
   The following participants must also disclose household income and assets in addition to maintaining MoHealthNet benefits:
   a. MO HealthNet Blind Pension
   b. MO HealthNet for Children and/or Families
   c. MO HealthNet spenddown cases over $1,200
   d. Persons who are found ineligible for MO HealthNet benefits

PAGE TWO: Application for Missouri Kidney Program Assistance

Name = use full legal name with middle initial, no nicknames

Sex = check male or female

Physical Address = the permanent address where the applicant resides. Street/Route #, City, State and Zip Code must all be listed for the applicant. If the applicant receives his/her mail at a PO Box, note the mailing address in the comments to explain the reason for difference in address.
In addition to the PO Box, please also note applicant's physical address to verify that he/she is a resident of Missouri. ***Zip code accuracy is of the utmost importance when requesting assistance with medications.***

NOTE: In a few instances, a relative or Power of Attorney is responsible for processing mail for an applicant. If this is the case, please note the applicant's address, and then also note the name, relationship and address of the person responsible for processing mail.

County (if St Louis, indicate city or county) = the county where the applicant resides (not the mailing address if mailing address is not applicant's home.).

Telephone number, including area code = applicants phone number. If the applicant does not have a telephone, please note a contact person-name, relationship and phone number.

Cell Phone Number, including area code Include mobile phone numbers when possible.

Social Security Number = the nine digit social security number

Date of Birth = Month, Day, Year

Marital Status = check married or single

Number of Dependents, including (1) person for yourself = number of dependents in household that are dependent on applicant and/or spouse. Follows IRS dependent criteria. Person filing income taxes counts as 1 dependent and spouse living in home counts as 1 dependent making 2 dependents in household.

Race= circle race

Medicare # = the Medicare Beneficiary Identification, the format is 11 characters and includes numbers and letters, a unique ID, not a SSN. *A copy of the card is required.*
Effective Date (Part B) = the effective date of part B as shown on the card using mm/dd/yyy.

If not eligible for Medicare, indicate reason = list the reason the applicant does not have and/or is not eligible for applying for Medicare. *Note date applicant applied for Medicare and Social Security. MoKP requires application and approval/denial for Medicare.*

Chapter 3 Application for MoKP Assistance	Section 030 Participant Application

MO HealthNet (Medicaid) = the nine digit MO HealthNet case number as indicated on the MO HealthNet card. All Applicants that are financially eligible for MO HealthNet must apply for and cooperate with MO HealthNet and maintain Active status.

If not eligible for MO HealthNet (Medicaid) indicate reason = list the reason why the applicant is not eligible for MO HealthNet. Submit a copy of the rejection letter.

Military benefits = is the applicant or spouse, eligible for military benefits – check yes or no. If yes, please attach a copy of the applicant's TriCare or ChampVA card. If the applicant is only eligible for assistance through the VA center please note as such in the Justification for Funding narrative section below.

Blind Pension benefits = are you receiving Blind Pension– check yes or no. If the applicant is receiving Blind Pension, income and asset documentation must be attached.

Other Insurance = list all insurance coverage, check the type of coverage, provide the name of the policyholder, policy number, group number, phone number and effective date. *A copy (front and back) of the private insurance card(s), both medical and prescription drug cards -must be submitted with the application.*

PAGE THREE:

Current Status = check dialysis or transplant; for dialysis applicants list the date of the first dialysis at your facility; for transplant applicants list the date of the current transplant and check whether the transplant was a Cadaver (CAD), Living Related Donor (LRD) or Living Unrelated Donor (LUR).

Type of Assistance Requested = check all requested assistance and where indicated state the estimated (or actual) dollar amount per month.

Diagnosis = select the diagnosis listed on the CMS Form 2728. If not listed, please select other diagnosis.

Justification for funding = a detailed justification for funding is required. The justification should include both financial and socioeconomic need.

Date = Month, Day, Year the social worker signed the application.

Social Worker Signature = Signature of social worker submitting the application.

Facility = Facility where this applicant will be followed.

PAGE FOUR:

MoKP Participant Agreement Form (MoKP Form 107a)
This agreement form must be read, completed and signed by the applicant with signature, date, Social Security number and date of birth at the time of application and then annually.

Chapter 3 Application for MoKP Assistance	Section 030 Participant Application

PAGE FIVE:

Consent for Medicare Part D Enrollment (MoKP Form 117)
This form must be completed and signed by all applicants applying for routine medication assistance.

Name = use full legal name with middle initial, no nicknames

Mailing Address = the permanent address where the applicant resides. Street/Route #, City, State and Zip Code must all be listed for the applicant.

Zip Code = Zip code accuracy is of the utmost importance when requesting assistance with medications**.**

Physical Address = if the applicant receives his/her mail at a PO Box. Please note the applicant's physical address to verify that he/she is a resident of Missouri.

Telephone number, including area code = applicants phone number. If the applicant does not have a telephone, please note a contact person-name, relationship and phone number.

Cell Phone Number, including area code *Include mobile phone numbers when possible.*

Date of Birth = Month, Day, Year

List only the medications that you purchase from a pharmacy other than Kilgore's Medical Pharmacy. If necessary, attach another sheet of paper.

Applicant Signature and Date of Signature = signature acknowledges the document is read and understood

Guardian or Relationship is signing for applicant

PAGE SIX:

Prescription Order Form (MoKP Form 103)
If the applicant is needing assistance with medications through our Centralized Drug Program this form must be completed and signed by a physician or Advance Practice Nurse and faxed directly to Kilgore's Medical Pharmacy at 573-443-4754.

PAGE SEVEN:

Prescription Distribution Consent Form
Complete this form ONLY if applicant wants medications mailed to address other than their own (example: facility).

PAGE EIGHT:

Chapter 3 Application for MoKP Assistance	Section 030 Participant Application

Mileage and Public Transportation Form (MoKP Form 115)
See Chapter 4 Section 020

Vendor Transportation Form (MoKP Form 115a)
See Chapter 4 Section 020

OPTIONAL FORM:

Income and Asset Information (MoKP Form 107)
Income and asset verification is required for applicants who are:

- Not eligible for MO HealthNet
- Eligible for MO HealthNet Blind Pension
- Eligible for MO HealthNet for Children and/or Families
- Eligible for MO HealthNet Spend Down over $1,200

Income Eligibility
When completing this form, list all people in your home who are either supported by you or contributing support to the household. Enter all income of each individual on the appropriate lines. Verification of all income sources is required.

For purposes of eligibility, MoKP considers the income of all dependent's income (including dependent child social security) who are contributing to the support of the household where the applicant resides. Dependents are determined by IRS guidelines.

Asset Eligibility
The MoKP asset limit is $15,000 per household. Assets include all liquid assets and/or real property not including the residence.

Full disclosure of all household income and assets is required. If the household does not have income, disclosure of income and assets of the person(s) providing the assistance for housing, food, personal care items, etc. is required.

If filed, a copy of the Federal and state tax income tax returns, including copies of W2s, 1099s, and supporting schedules are required for establishing income eligibility.

Chapter 4 Patient Assistance through Facility Reimbursement	Section 010 Overview Statement

OVERVIEW STATEMENT:

Assistance through facility reimbursement is provided for eligible Missourians in the following forms: transportation reimbursement, private insurance premium reimbursement and immunosuppressive drug medication co-pays in cases where participants are required by their insurance provider to use a Specialty Pharmacy.

The following sections explain each type of reimbursement assistance and the process for application.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 4	Section 020
Patient Assistance through Facility Reimbursement	**Transportation Reimbursement**

Transportation assistance is available for the round trip expense from the patient's home to the nearest dialysis clinic. For in-center hemodialysis patients this would be the round trip to the dialysis unit generally three days a week. For home and peritoneal dialysis, the transportation assistance would be for the two to three week training period and then up to two days a month for clinic visits and/or lab work performed at the dialysis clinic. Other doctor office visits, transportation to and from the hospital, etc. are not covered.

MoKP will reimburse for the least expensive form of transportation appropriate for the patient, including but not limited to:

1. Mileage: Patient, family, friends, or community member drive patient to and from treatment—use Google Maps to determine the number of miles
2. Public Entity Transportation (Call-A-Ride, Share-A-Fare, City Bus Pass)
3. Vendor transportation

Please see Chapter 2 Eligibility Criteria to determine if a patient is eligible for Transportation Reimbursement.

MILEAGE AND PUBLIC TRANSPORTATION PROCESS:

An MoKP Application for Assistance must be submitted to request transportation assistance including Mileage and Public Transportation Form (MoKP Form 115). If the patient requires more than 14 dialysis trips per month, please note in the comment section the number of treatments the patient will have per month. A new request must be completed when there is a change in mode, cost, patient address or facility.

VENDOR TRANSPORTATION PROCESS:

An MoKP Application for Assistance must be submitted to request transportation assistance including a Vendor Transportation Form (MoKP Form 115a). If requesting vendor reimbursement, two written vendor quotes are required. If the patient requires more than 14 dialysis trips per month, please note in the comment section the number of treatments the patient will have per month.

Vendor transportation requests will be reviewed by a committee made up of MoKP staff and MoKP Advisory Council members for the approval/denial process.

A new request must be completed when there is a change in mode, cost, patient address or facility. All approved vendor transportation will be reviewed every three to six months to confirm continued need.

RECORDS RETENTION: MoKP requires original documentation be kept for five years for purposes of transportation verification. The Transportation Reimbursement Verification (MoKP Form 116) must be completed each month.

Please see Chapter 1 Section 030 for information regarding the Monthly Voucher Process and how to request reimbursement for transportation expenses.

MoKP reserves the right to alter the Transportation Policy including funding.

The level of transportation reimbursement assistance can change at any time due to changes in MoKP funding from the Missouri General Assembly.

Chapter 4	Section 030
Patient Assistance through Facility Reimbursement	**Private Premium Reimbursement**

MoKP offers reimbursement for employee group health plan and private insurance premiums (including ACA and Medicare Supplement Plans). Premium assistance is only offered to persons with kidney transplant and using the Centralized Drug Program.

When evaluating whether to provide the premium assistance, MoKP may consider not only the financial circumstances of the patient, but the cost savings that will accrue to MoKP. MoKP reserves the right not to reimburse for premiums when there is no cost savings to MoKP, or no net benefit to the patient.

Each transplant facility can decide whether they pay the insurance payments directly to the insurance company on behalf of the participants, or if the participant pays for their own premiums and receives reimbursement from the facility. MoKP will reimburse the facility after payment has been made to either the participant or the insurance company.

Facilities must retain copies of premium notices, payroll stubs showing premium payments, and/or canceled checks in the facility files.

All records and supporting documents must be kept for five years to meet MoKP audit requirements.

Chapter 5	**Section 010**
Centralized Drug Program (CDP)	**CDP Overview**

MoKP provides medication assistance through a contracted pharmacy, Kilgore's Medical Pharmacy. See Chapter 2 for eligibility requirements.

Benefits of using the Centralized Drug Program (CDP) include:

1. Medications on the MoKP formulary are dispensed at no cost to the participant. Medications not on the MoKP formulary can be dispensed, but at a cost to the participant. The MoKP formulary is located on the MoKP Database and the MoKP public website.
2. Medications can be mailed to the participant's home or to the participant's dialysis facility. If the participant wants medications to be sent to an address not their home, such as their dialysis facility, they must also complete Kilgore's Prescription Distribution Consent Form. Please see Chapter 7 for the form. Kilgore's Medical Pharmacy will determine the most appropriate delivery method.
3. MoKP staff will work with Kilgore's Medical Pharmacy to enroll participants in a Medicare Part D Prescription Drug Plans (PDP). Plans will be selected based on the participant's medications and cost evaluation.
4. Kilgore's Medical Pharmacy offers a SYNC program: The pharmacy calls the participant one time a month to refill medications and all medications are refilled at the same time. The program is convenient and encourages compliance.
5. In coordination with MoKP, Kilgore's Medical Pharmacy can only dispense a 30 day supply of medications

Please see Chapter 2 for Eligibility Requirements.

Please see Chapter 3 for instructions on how to complete the MoKP Application.

The Prescription Order Form (MoKP Form 103) and Consent for Medicare Part D PDP Enrollment (MoKP Form 117) must accompany the application when medication or immunosuppressant assistance is requested.

The prescription order form must be faxed to Kilgore's Medical Pharmacy at 573-443-4754.

The MoKP requires that participants approved for assistance through the CDP routinely use the contracted pharmacy for all of their MoKP Formulary medications. If the recipient is not using the CDP in a 90 day period, an email to the social worker and a letter to the participant is sent to determine notify them they may be terminated from the MoKP CDP for non-use.

Chapter 5	**Section 020**
Centralized Drug Program (CDP)	**CDP Formulary**

The Centralized Drug Program (CDP) formulary was developed by a group of physician advisors and approved by MoKP Advisory Council. The formulary is reviewed and revised as needed with assistance from advisory physicians and approved by the MoKP Advisory Council.

Requests for changes to the formulary must be in writing and submitted to the Director of MoKP.

The current formulary can be accessed on the MoKP public website at https://mokp.missouri.edu/public/missouri%20kidney%20program.html

You may sort the formulary in one of two ways:
1. Category
2. Drug Name

Chapter 5	**Section 030**
Centralized Drug Program (CDP)	**Payor of Last Resort**

PAYER OF LAST RESORT:
Please see Chapter 2 Section 030 for information regarding coordination of benefits. MoKP is a payer of last resort. MoKP will pay for medication copays on formulary medications only after all other payers have been billed.

Some insurance plans require the use of a specialty pharmacy. In these cases, the MoKP contract pharmacy cannot dispense medication and the participant cannot be approved for CDP Immunosuppressants.

LETTER OF CREDITABLE DRUG COVERAGE:
MoKP requires a copy of a "Creditable Coverage" letter every year when the participant is approved for the CDP.

Each employer who offers an employee group health plan is required to annually issue a letter to all of their employees stating whether or not their insurance is deemed "creditable". Coverage is "creditable" if the coverage equals or exceeds the drug coverage under Medicare Part D. The letter should also state whether or not the employee's health care insurance will change, be terminated, increase in premium cost, or have no impact if the participant would decide to enroll in a Medicare Part D plan.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 6 **Transplant Assistance Reimbursement**	**Section 010** **Transplant Assistance**

Kidney Transplant recipients or kidney donors may be eligible for financial assistance to help defray out-of-pocket living expenses associated with transplantation. The recipients/donors do not have to be enrolled for other types of MoKP assistance. The kidney transplant recipient MUST be a resident of Missouri, however the kidney donor does NOT have to reside in Missouri.

GUIDELINES FOR ASSISTANCE:

- Transplant assistance requests can be made FOR up to $1,000 per transplant recipient and/or donor.
- All requests will be considered on a case-by-case basis by the MoKP Director.
- Although income eligibility guidelines do not apply to transplant assistance, financial means may be considered when evaluating requests.
- Partial awards may be requested for both the recipient and donor—with the total combined not to exceed $1,000.
- Dental and/or other medical expenses directly or indirectly related to the transplant are not covered.
- Assistance can be requested for non-medical transplant expenses incurred up to six months after the surgery.

PROCEDURE TO APPLY:

1. The MoKP contracted transplant facility social worker (or other staff member) must submit a written request to the MoKP Director the need. Example: lost wages while recuperating from donation of kidney, lodging expenses post-transplant to remain close to the facility, child care when adults at facility post-surgery, rent and utilities while on sick leave, travel expenses, etc. See sample letter.
2. The MoKP contracted transplant facility staff member making the request will be notified in writing of the outcome of the request. MoKP will reimburse the MoKP contracted transplant facility only after the transplant has occurred.
3. Once the facility has made payment to the recipient and/or donor, then verification of the payment should be sent to MoKP offices for reimbursement.

DATE

Laurie Hines
Missouri Kidney Program
2800 Maguire Blvd, Ste B110
Columbia, MO 65211
RE: Transplant Donor Assistance

Dear Ms. Hines:

I am requesting transplant assistance reimbursement in the amount of $_____($1,000 maximum) to help NAME (s) with non-medical expenses related to transplant.

The letter must include the following:

1) Name of person(s) to receive the funds. (donor and recipient can share)

2) If $ for recipient, confirm that recipient is a resident of Missouri. Donor does not have to reside in Missouri.

2) Date of transplant.

3) Why the funds are needed and for what?

Funds are needed to help recipient and/or donor recover from surgery.

Examples include child care, lost wages, living expenses, transportation, groceries, etc.

Any other information you would like to share about this patient(s).

Sincerely,

Transplant Social Worker

SAMPLE

Chapter 7 **Forms and Examples**	**Section 010** **Forms**

All forms listed in the following chapter are available through the MoKP Database. How to access to the MoKP Database is available in Chapter 1 Section 010.

MoKP Form 101:	Application Worksheet
MoKP Form 102:	MoKP Application
MoKP Form 103:	Prescription Order Form
MoKP Form 107:	Income and Asset Information
MoKP Form 107a:	MoKP Participant Agreement
MoKP Form 109:	Transplant Update Form
MoKP Form 115:	Mileage and Public Transportation Form
MoKP Form 115a:	Vendor Transportation Form
MoKP Form 116:	Transportation Reimbursement Verification
MoKP Form 117:	Consent for Medicare Part D Enrollment
Kilgore’s Form:	Kilgore's Prescription Distribution Consent Form

Missouri Kidney Program

University of Missouri Health

Application Worksheet

This form, with the supporting documentation, must be faxed after the application has been submitted.

Patient Name: ___________________________ SS# ______________________

Required Documentation:

1. Signed and dated Participant Agreement (MoKP Form 107A). This page gives MoKP authority to handle issues that may arise with Medicare, MoHealthNet, Private Insurance, etc.
2. Copy of Medicare card and Medicare Prescription Drug Plan card (Part D)
3. Copy of front and back of Commercial Insurance Card (Medicare Supplement/Medigap; Employer Group Health; Private/Personal; and/or Medicare Advantage). If policy includes prescription drug coverage, then the Notice of Creditable Coverage must also be included.

Other Documentation, if applicable to the requested benefit:

1. If requesting assistance with routine medications and/or immunosuppressants, then MoKP requires the Prescription Order Form (MoKP Form 103) and Consent for Medicare Part D Enrollment (MoKP Form 117) be completed and sent to MoKP. Please send the Prescription Order Form directly to Kilgore's Medical Pharmacy as indicated on the form.
2. If requesting transportation reimbursement, then MoKP requires either the Mileage and Public Transportation Request Form (MoKP Form 115) or the Vendor Transportation Request Form (MoKP Form 115a) be sent to MoKP.
3. When the applicant does not qualify for MoHealthNet, receives Blind Pension, or has a MoHealthNet SpendDown over $1,200, then we require Income and Assets Information with supporting documentation (MoKP Form 107).

Your on-line application will be processed in a timely manner upon receipt of this form and the supporting documentation.

Applications will not be approved until all supporting documentation is received.

Submitted by: ______________________________________
Print Social Worker Name

Facility Name: ______________________________________

MoKP Fax # 573-882-0167

Missouri Kidney Program
University of Missouri Health

MoKP Participant Application

COMPLETE ALL BLANKS • PLEASE PRINT CAREFULLY • USE BLACK INK

Name: ____ Sex: ☐ Male ☐ Female
Use Full Legal Name, No Nicknames

Physical Address: ____________________________________ __________________ ___________
Street/ Route #/ P.O. Box City Zip Code

________________________________ _______________ _________________
County (If St. Louis, indicate city or county) Telephone Number Cell Phone Number

Social Security Number ______ - _____ - _______ Date of Birth __________________

Marital Status (check one): ☐ Married ☐ Single Number of Dependents (including yourself) ________

☐ Asian ☐ African American ☐ Native American ☐ Pacific Islander ☐ Hispanic ☐ White

Medicare #: ______________________ Effective Date (Part B): ________________
ATTACH COPY OF MEDICARE CARD AND MEDICARE PRESCRIPTION DRUG CARD (PART D)

If not eligible for Medicare, indicate reason ____

Medicaid # ___________________________

If not eligible for Medicaid, indicate reason ____

Are you, or your spouse, eligible for military benefits? You ☐ Yes ☐ No
Your Spouse ☐ Yes ☐ No
Are you receiving blind pension benefits? ☐ Yes ☐ No

Other Insurance ____
Type of Coverage: ☐ Medicare Supplement/Medigap ☐ Employer Group ☐ Private/Personal ☐ Medicare Advantage

If different from patient:
Name of Policyholder: ____________________ Policy #: ____________________________

Date of Birth: ___________________________ Group #: ____________________________

Social Security #: ________________________ Phone #: ____________________________

Effective Date: __________________________

Fax the completed application to Missouri Kidney Program at (573) 882-0167.

MoKP Participant Application

THIS PAGE IS TO BE COMPLETED BY THE SOCIAL WORKER

CURRENT STATUS: ☐ Dialysis ☐ Transplant

If Dialysis: Date of first dialysis at current facility ____________ (MM-DD-YYYY)

If Transplant: Date of current transplant _____________ (MM-DD-YYYY)
Type of transplant, select one: ☐ CAD ☐ LRD ☐ LUR

TYPE OF ASSISTANCE REQUESTED:

☐ Transportation: Estimated $_______ / month

☐ Routine Medications*

☐ Immunosuppressants*

☐ Insurance Premiums: $ _______ / month
Transplant recipients only

DIAGNOSIS: Above information based on ESRD Medical Evidence Report – Form CMS 2728

☐ Diabetes Type I
☐ Diabetes Type II
☐ Hypertension
☐ Diabetes (Type I) AND Hypertension
☐ Diabetes (Type II) AND Hypertension
☐ Other diagnosis: __________________________

JUSTIFICATION FOR FUNDING: (justification should include both financial and socioeconomic need)

____
Date

____
Social Worker Signature

____
Facility

Fax the completed application to Missouri Kidney Program at (573) 882-0167.

Missouri Kidney Program
University of Missouri Health

Prescription Order Form

Date: ________________________

To: Kilgore's Medical Pharmacy **Fax #:** 573-443-4754
Phone Numbers: Toll Free (866) FIL-MOKP (345-6657) Local 573-443-8556

From MoKP Facility Name: _________________________ **Phone #:**_______________

Patient Name (PRINT):_________________________________**DOB:** ___/___/____

Allergies: ____

Required for Transplant Patients:

Facility Patient Received Transplant: _________________________________

Hospital Discharge Date after Transplant: _____________________________

Diagnosis Codes for Immunos ICD-10:_______________

	Medication	Strength	Directions	Qty	Refills
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Please provide a complete list of medications not included on this form to ensure we have an accurate medication list.

X______________________________ **Substitution Permitted**

X______________________________ **Dispense as Written**

X______________________________ **Date**

X______________________________ **Date**

PRINT Prescriber's name: ____

Medications are to be sent to: (check one): Facility _______ Patient's home_______

(Facility must submit a Kilgore's Prescription Distribution Consent Form if requesting medications be sent to facility.)

Address: ____ **(street – no PO boxes)**

____ **(city, zip)**

Missouri Kidney Program
University of Missouri Health

Income and Asset Information

Complete this page if one of the following is true: the applicant (1) has MO HealthNet Blind Pension (2) has MO HealthNet spenddown over $1,200/month. (3) has been found to be ineligible for MO HealthNet due to not meeting disability requirements or (4) is over the asset/resources limit for MO HealthNet.

List below all dependents and/or individuals living in your home, including yourself, who are either supported by you or contributing support to the household. Enter all incomes of each individual on the appropriate lines.

1. ______________________________ Name ____ Age ___SELF___________ Relationship $________________ Total Monthly Income*
$____________ Social Security $____________ Blind Pension $________________ Employment/Pension $____________ Other

2. ______________________________ Name ____ Age ______________________ Relationship $________________ Total Monthly Income*
$____________ Social Security $____________ Blind Pension $________________ Employment/Pension $____________ Other

3. ______________________________ Name ____ Age ______________________ Relationship $________________ Total Monthly Income*
$____________ Social Security $____________ Blind Pension $________________ Employment/Pension $____________ Other

4. ______________________________ Name ____ Age ______________________ Relationship $________________ Total Monthly Income*
$____________ Social Security $____________ Blind Pension $________________ Employment/Pension $____________ Other

Total Combined Monthly Income for the blanks marked with an '*': $________________

Assets

Checking Account(s) $_______________ CDs/IRAs $________________

Savings Account(s) $_______________ Stocks/Bonds/Mutual Funds $________________

Other (money market, credit union accounts, etc.) $_____________________ Type: ___________

Life Insurance: Cash Surrender value $____________________ or circle, if policy is an irrevocable burial plan.

DOCUMENTATION REQUIRED: (The following are examples. **ALL INCOME AND ASSETS MUST BE DISCLOSED.)** **Current bank statements, savings account statements, credit union statements, and all current CDs/IRAs/Stocks/Bonds/Mutual Funds/401K statements. Also include a copy of the last (within two years) Federal and State Income Tax returns, including copies of W2s, 1099s and supporting schedules. Your application will not be processed without this information and documentation.**

Missouri Kidney Program
University of Missouri Health

MoKP Participant Agreement

Please read, sign and date, and return promptly. An agreement must be signed every year before any assistance can be approved. Completed forms may be faxed to: 573-882-0167

By signing this, I understand and agree to the following:

I understand that only Missouri residents who are citizens are eligible for this program. By signing this form I state that I am a US citizen, or legal resident of the US and a Missouri resident. I will contact the program immediately, if I am no longer a resident of Missouri.

I authorize my dialysis or transplant facility to share information relating to my health condition or payment made for my healthcare to the MoKP.

I agree that before I receive any assistance from MoKP, I may be required to apply for MO HealthNet, Medicare, or any other available resources as directed by MoKP.

I understand failure to cooperate with the program may result in loss of MoKP benefits or termination from the program or both.

I understand the MoKP is a state funded program, subject to availability of funds, and is payer of last resort.

I understand MoKP assistance is reimbursement only and all payments are made directly to the dialysis or transplant facility on behalf of the MoKP participant.

I agree to inform MoKP of any changes, within 10 days, in household dependents or income, MO HealthNet, Medicare or private insurance coverage or benefits, or change of address.

I agree to allow MoKP to verify any and all documentation and information provided for this application and any future MoKP applications submitted on my behalf. I will provide MoKP with paystubs, tax returns (federal and state), bank statements for all accounts, upon request. I authorize MoKP to obtain documentation from my insurance company/carrier/administrator.

I agree that the Missouri Department of Social Services, Division of Family Support, can release any information and documentation to the MoKP regarding my MO HealthNet case.

I authorize MoKP to talk to any healthcare provider, family member or legal guardian, regarding benefits provided to me under this program.

I understand that the information submitted by me will be treated as confidential by MoKP and its contractor pharmacy.

For Centralized Drug Program/MoKP Contracted Pharmacy applicants only:

I agree to use the MoKP contracted pharmacy/Centralized Drug Program pharmacy (Kilgore's Medical Pharmacy) as my primary pharmacy for Missouri Kidney program formulary medications.

I agree to forward and assign to MoKP contracted pharmacy any insurance payments I receive for medications provided by MoKP through the MoKP contracted pharmacy.

I agree that the Centralized Drug Program vendor may release information to my insurance company including but not limited to, diagnosis or treatment records, for payment of claims.

I agree that by signing this form, MoKP can manage my Medicare Part D plan. A consent form must be signed every year.

By signing I agree that the information provided by me and about me on this application is accurate to the best of my knowledge. I understand it is against the law to obtain or attempt to obtain assistance to which I am not entitled.

______________________________	______________________
Participant Signature	**Date**
______________________________	______________________
Social Security Number	**Date of Birth**

The University of Missouri does not discriminate on the basis of race, color, religion, national origin, ancestry, sex, sexual orientation, gender identity, gender expression, age, genetic information, disability, or status as a protected veteran.

Missouri Kidney Program
University of Missouri Health

Transplant Update Form

Transplant Facilities:

Complete this form when Missouri Kidney Program participant is transplanted at your facility. In order for this participant to remain on the program, you must include information regarding insurance coverage for immunosuppressants.

Name: ____

Birth Date: ____________________ Social Security Number: _______________________

Transplant Date: ____

Transplant Facility: ____

Donor Type: (circle one) Deceased Donor Living Unrelated Donor Living Related Donor

Payor Type: (circle all applicable) Medicare Medicaid Private Insurance

Private Insurance Information: Must include a copy of the front and back of card.

Name of Insurance Provider: ____

Effective Date: ____

Prepared by: ______________________________

Telephone: _______________________________

Please fax the completed form to Missouri Kidney Program at 573-882-0167.

Missouri Kidney Program
University of Missouri Health

Mileage and Public Transportation Form

Patient Name: ________________________________ Date _________
PLEASE PRINT

Facility Name: __________________________________

Social Worker: ________________________________

Mode requested (check one)

□ Mileage for private vehicle: total miles _________ **(daily round trip)**
  □ Calculation based on Google Maps (circle one) yes no
  □ Calculation based on __________________________

□ Public Transportation ($ = round trip)
  □ Share-A-Fare $_____________ **(daily round trip)**
  □ Call-A-Ride $_______________ **(daily round trip)**
  □ City Bus Line (i.e. bus passes) $____________________

Comments: ____
____
____
____
____
____
____
____
____
____
____
____

FOR OFFICE USE ONLY:
Approved by MoKP Regional Coordinator: _______________________

Effective Date: ___________ Approved monthly cap: ______________

Missouri Kidney Program
University of Missouri Health

Vendor
Transportation Form

Patient Name: ________________________________ Date __________
PLEASE PRINT

Facility Name: ________________________________

Social Worker: ________________________________

Vendor Transportation: must submit two quotes

Quote 1: Attached Vendor ______________________________ $ ______ (daily round trip)

Quote 2: Attached Vendor ______________________________ $ ______ (daily round trip)

Is public transportation available for use? ☐YES ☐NO **If yes, please explain** _______________

Is patient going to the closest facility? ☐YES ☐NO **If no, please explain** _______________

Does the patient require assistance ambulating? ☐YES ☐NO **If yes, please explain** __________

Does the patient have a family member/close friend who could transport one-way? ☐YES ☐NO
Please explain ______________________________

Can this patient's shift be changed to accommodate less expensive transportation? ☐YES ☐NO
Please explain ______________________________

Comments: ______________________________

By signing this form, I acknowledge I have examined all lower cost transportation options prior to submitting this application for vendor transportation assistance.

Social Worker Signature: ______________________________

FOR OFFICE USE ONLY:
Approved by Transportation Vendor Committee: ______________________________

Effective Date: _______ Review Date: _______ Approved monthly cap: ___________________

Transportation Reimbursement Verification

Note: Facility must keep all original supporting documents for five years to meet MoKP audit requirements.

Facility Name: ____

Facility Address: ____

Phone Number: __________________________ Fax Number: ____________________________

Patient Name: ____________________________

Patient Address: __________________________ City: ____________, MO Zip: _______________

Roundtrip Miles - round to nearest tenth: ____________________

Month/Year of Treatment: ____________________

Dates of Dialysis Treatments – circle ALL dates of treatment

1	**2**	**3**	**4**	**5**	
6	**7**	**8**	**9**	**10**	
11	**12**	**13**	**14**	**15**	
16	**17**	**18**	**19**	**20**	
21	**22**	**23**	**24**	**25**	
26	**27**	**28**	**29**	**30**	**31**

Total number of treatments: ____________________________

Amount of reimbursement (total miles x $0.23): _________________

Additional comments or special circumstances (e.g. one-way mileage only): ________________

____

____

Participant Signature: ____________________________________ Date: __________________

I attest that the information on this form is true and accurate, as a condition of continued participation in the Missouri Kidney Program.

Social Worker Signature: ____________________________________ Date: __________________

I attest that the information on this form is true and accurate, as a condition of continued participation in the Missouri Kidney Program.

For facility use only: (if checks are mailed to the patient, indicate date mailed)____________
Patient initials/date that check was received from facility:__________________________________

Missouri Kidney Program
University of Missouri Health

Consent for Medicare Part D Enrollment 2020

Please complete information for enrollment in a Part D - prescription drug plan.

Full Name: ____________________ ____________________ ______________
Last Name (include suffix: Jr, Sr, II, etc) First Name Middle Initial

Address: ____

City: ________________________

Zip Code: ________________________ County: ____________________

If different, Physical Address if mail is PO or address ______________________________________

Home Phone Number:______________________ Cell Phone Number: ____________________

Date of birth: __________________ (Month/Day/Year)

List **only** the medications that you purchase from a pharmacy **other** than Kilgore's Medical Pharmacy. If necessary, attach another sheet of paper.

Drug Name / Dosage	Quantity	Days Supply (per month, per week, etc)

- I will notify Missouri Kidney Program of any changes to the above information.
- I authorize the Missouri Kidney Program to enroll me in the Medicare Part D Prescription Drug Plan that meets my medication needs.
- I acknowledge that Kilgore's Medical Pharmacy will notify the Missouri Kidney Program when it is necessary to change my prescription drug plan enrollment.
- I understand this consent form is valid through October 31, 2020.

Signature: ____ **Date:** ______________

Guardian or Relationship if signing for patient: ________________________________

FOR OFFICE USE ONLY:
MoKP# **Coordinator:** **Social Worker:**
Medicare #
Part A Date: **Part B Date**
Current PDP:
Comments:

Prescription Distribution Consent Form

I authorize Kilgore's Medical Pharmacy to send my prescriptions to:

____
Facility or Person

located at:

____
Street

____
City State Zip Code

I give my authorization for this to happen anytime a medication is ordered by myself, my physician, or another care giver.

My authorization will remain in effect as long as I am part of the Missouri Kidney Program, unless I provide written notification to Kilgore's Medical Pharmacy's revoking my authorization.

By signing this authorization, I also understand that Kilgore's Medical Pharmacy cannot be responsible for the medications and their handling when mailed to the entity/person listed above.

____ ________________________
signature date

____
print name

If a personal representative (someone authorized to make health care decisions on behalf of the individual) signs this form, the representative must also provide a description of that person's authority to act on behalf of the patient.

700 N. Providence, Columbia, MO 65203 Ph.# 866-345-6657

Revised July 11, 2016

FACILITY AGREEMENT Facility Number: «FACNO»

THIS AGREEMENT is entered into as of the first day of July, «ThisYear» between THE CURATORS OF THE UNIVERSITY OF MISSOURI, a public corporation of the State of Missouri (University) for Missouri Kidney Program (MoKP), and **«FULLNAME»**, a transplant/dialysis facility serving End-Stage Renal Disease (ESRD) patients of the State of Missouri (Contractor).

University, for the use of MoKP, received an appropriation from the General Assembly for support of renal disease in a statewide program. Reimbursement for pre-approved direct costs (Transportation Assistance, Premiums, Immunosuppressant Drug Co-Pays, and Transplant Assistance) will be disbursed monthly.

The parties have entered into this Agreement for the accomplishment of the Award, which has been determined to be within the purpose indicated by the above-mentioned appropriation, and agree as follows:

1. For the consideration hereafter set forth, Contractor agrees to provide the necessary personnel, facilities, related resources and skills to perform and accomplish the Award in accordance with the Award Assistance Guidelines (Appendix I).

2. Commencing July 1, «ThisYear» and continuing through June 30, «NextYear», Contractor shall perform the work called for in the Award Assistance Guidelines (Appendix I).

3. During the period of performance set forth above, as reimbursement for pre-approved direct costs under the terms of this Agreement, University agrees to pay Contractor an amount agreed upon by the parties for pre-approved direct costs. Payments will be made upon receipt of approved electronic submission of expenses submitted by Contractor to University and received by

SAMPLE

University by monthly voucher close date. See Appendix II Monthly Voucher Reimbursement Schedule. Contractor further agrees and understands that the funds from which University will make these payments are derived from appropriated state funds, and in the event University should not receive these funds or a portion of, for whatever reason, University may terminate this Agreement or require the reduction in the extent of services contracted hereunder to match the available funds.

4. Contractor agrees that any line item variation from the MoKP Facility Award Assistance Guidelines, which is attached hereto and incorporated by reference as Appendix I, must be approved in advance in writing by the MoKP for University.

5. Contractor agrees that, for the purpose of audit or examination, University and governmental auditors and representatives shall have access at any reasonable time to any of the books, documents, papers and records of Contractor recording receipts and disbursements of any of the funds made available to Contractor under this Agreement. Contractor further agrees that any audit exception noted by governmental auditors or University auditors or representatives shall be refunded to University as necessary by Contractor and shall be the sole responsibility of Contractor after exhaustion of all administrative and legal remedies.

6. Contractor agrees that all funds received under this Agreement will be held and used by Contractor for the purposes billed and reimbursed for, and none of the funds so held or received shall be diverted to any other use or purpose.

7. Contractor agrees to abide by and comply with the policies and procedures outlined in the MoKP Facility Guidelines Manual and any amendments thereto which may be issued during the performance of this Agreement.

SAMPLE

8. Contractor agrees not to deny MoKP assistance under this Agreement to Missouri residents due to the resident's inability to pay.

9. Contractor understands and agrees that University is responsible for the administration of this Award and agrees to comply with all requests and directives which may be given by University in the implementation or accomplishment of the Award.

10. Contractor agrees to furnish financial and final reports to University through MoKP in compliance with requests, schedules and deadlines for such reports and information.

11. Contractor agrees that this Award will be directed by

___________________________________ (Single Point of Contact),

___________________________________ (Social Worker),

___________________________________, (Administrator)

and Contractor will not substitute any other person as Single Point of Contact without securing written permission of University in advance. Contractor further agrees that its Single Point of Contact is the person to whom all official notices and requests relating to the performance of this Agreement should be addressed.

12. Contractor agrees that copies of any publications relating to the MoKP are to be furnished to University for the MoKP within a reasonable time prior to publication or distribution for review and approval.

13. The parties mutually agree that any clause or provision required by law, rule or regulation to be inserted herein shall be deemed to be incorporated herein by reference as though fully set forth and shall constitute a part of this Agreement, and that this Agreement may be amended in writing, on the application of either party to insert any such required provision.

SAMPLE

14. The parties mutually agree that either party may terminate this Agreement by giving thirty (30) days advance written notice of intent to terminate to the other party, or the MoKP may implement reduction as stated in paragraph 3 above.

15. The parties mutually agree that this Agreement shall be binding upon and inure to the benefits of the parties hereto and their successors and assigns, but neither party may assign this Agreement without advance written consent of the other.

16. Contractor attests that it has the proper authority to do business in the State of Missouri.

17. This Agreement shall be governed by the laws of the State of Missouri. The parties have caused this Agreement to be executed by their duly authorized representatives as of the first day of July, «ThisYear».

18. The University serves from time to time as a Contractor for the United States government. Accordingly, the provider of goods and/or services (Contractor) shall comply with federal laws, rules and regulations applicable to subcontractors of government contracts including those relating to equal employment opportunity and affirmative action in the employment of minorities (Executive Order 11246), women (Executive Order 11375), persons with disabilities (29 USC 706) and Executive Order 11758, and certain veterans (38 USC 4212 -formerly [2012]) contracting with business concerns with small disadvantaged business concerns (Publication L. 95-507). Contract clauses required by the Government in such circumstances are incorporated herein by reference.

SAMPLE

THE MISSOURI KIDNEY PROGRAM

By ____
Laurie Hines
Director

THE CURATORS OF THE UNIVERSITY OF MISSOURI UNIVERSITY

By ____
Sponsored Programs Administration

SAMPLE

Facility Name and Address

____

____

__________________, _________________

Corporate Affiliation (if applicable)

____

By this signature I also attest that I am a duly appointed representative of the Contractor and have the authority to execute this Agreement on behalf of the Contractor.

By ___________________________________

Type:
Name _________________________________

Title _________________________________
CONTRACTOR

APPENDIX I

Facility: «FACNO»

SPOC: «FacSpoc»

MOKP FACILITY AWARD Assistance Guidelines FY «NextYear»

Reimbursement for pre-approved direct costs will be disbursed monthly if submitted in accordance with Appendix II Monthly Voucher Reimbursement Process. Contractor agrees to provide the necessary personnel, facilities, related resources and skills to perform and accomplish the work as follows:

ASSISTANCE

Centralized Drug Program

The Centralized Drug Program is available to patients who meet the eligibility requirements as outlined in the MoKP Facility Guidelines Manual. This provides medication assistance through a contracted pharmacy. **This assistance is not a direct cost to the facility so there is no reimbursement between the contractor and MoKP**. **To provide this assistance to your patients, we require a contract between the contractor and MoKP**.

THE FOLLOWING TYPES OF ASSISTANCE ARE DIRECT COSTS TO THE CONTRACTOR. PAYMENTS WILL BE MADE TO THE CONTRACTOR UPON RECEIPT OF PAID EXPENSE IF SUBMITTED IN COMPLIANCE WITH APPENDIX II MONTHLY VOUCHER REIMBURSEMENT PROCESS. MOKP DOES NOT MAKE PAYMENTS DIRECTLY TO VENDORS OR PATIENTS.

Transportation Assistance

Transportation funds are available to help cover expenses for patient travel to and from a dialysis facility. Patient eligibility requirements are outlined in the MoKP Facility Guidelines Manual.

Premiums

Financial assistance for Premium payments are allowed for a transplant patient's Medicare Supplemental insurance and major medical policies. Patient eligibility requirements are outlined in the MOKP Facility Guidelines Manual.

Immunosuppressive Drug Co-Pays

Immunosuppressive drug funds are available for pre-approved patients, who are required to use a specialty pharmacy by their insurance provider. Patient eligibility requirements are outlined in the MOKP Facility Guidelines Manual.

Transplant Assistance Program

These funds are awarded to transplant donors or recipients to help defray out-of-pocket non-medical expenses associated with transplantation. The kidney transplant recipient must be a Missouri resident. Contracted MOKP transplant facilities must submit a written request to the MoKP Director, as per the MoKP Facility Guidelines Manual. Funds are awarded on a case by case basis and if funding is available.

SAMPLE

Missouri Kidney Program APPENDIX II

Monthly Voucher Reimbursement Schedule

FY 2020

Data Entry Period (Request for Reimbursement)	Service Month (the month the service occurred)			MoKP issues check to facility
July 1, 2019– July 17, 2019	May 2019	June 2019	July 2019	July 23, 2019
July 19, 2019– August 21, 2019	June 2019	July 2019	August 2019	Aug 27, 2019
August 23, 2019– Sept 18, 2019	July 2019	August 2019	Sept 2019	Sept 24, 2019
Sept 20, 2019- October 16, 2019	August 2019	Sept 2019	Oct 2019	Oct 22, 2019
October 18, 2019- Nov 20, 2019	Sept 2019	Oct 2019	Nov 2019	Nov 26, 2019
Nov 22, 2019– December 18, 2019	Oct 2019	Nov 2019	Dec 2019	Dec 24, 2019
December 20, 2019 – January 15, 2020	Nov 2019	Dec 2019	Jan 2020	Jan 21, 2020
January 17, 2020- February 19, 2020	Dec 2019	Jan 2020	Feb 2020	Feb 25, 2020
February 21, 2020 – March 18, 2020	Jan 2020	Feb 2020	Mar 2020	March 24, 2020
March 20, 2020-April 15, 2020	Feb 2020	Mar 2020	April 2020	April 21, 2020
April 17, 2020- May 20, 2020	March 2020	Apr 2020	May 2020	May 26, 2020
May 22, 2020 – June 17, 2020	April 2020	May 2020	June 2020	June 23, 2020

SAMPLE

*Payments to patients/vendors must be made before requesting reimbursement from MoKP**

Put another way --

You have from:	To be reimbursed for services performed in:
July 1, 2019 to August 21, 2019	May and June, 2019
July 1, 2019 to September 18, 2019	July, 2019
August 1, 2019 to October 16, 2019	August, 2019
September 1, 2019 to November 20, 2019	September, 2019
October 1, 2019 to December 18, 2019	October, 2019
November 1, 2019 to January 15, 2020	November, 2019
December 1, 2019 to February 19, 2020	December, 2019
January 1, 2020 to March 18, 2020	January, 2020
February 1, 2020 to April 15, 2020	February, 2020
March 1, 2020 to May 20, 2020	March, 2020
April 1, 2020 to June 17, 2020	April, 2020
May 1, 2020 to June 17, 2020	May, 2020
June 1, 2020 to June 17, 2020	June, 2020

Payments to patients/vendors must be made before requesting reimbursement from MoKP

SAMPLE

Missouri Kidney Program Network
Voucher by Patient Listing

Vendor#0000000000-000 Coordinator: MoKP

DeptID:C0000000

MoCode:C0000

Facility Name: Test Facility

Name	Transp	Drug	Priv Prem	Supp	Transp Assist	Immuno	Educ	Total	Service Date
10/18									
Doe, Jane	$1820.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1820.00	10/2018
Doe, John	$ 34.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ 34.68	10/2018
Monthly Subtotal:	$1854.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1854.68	
11/18									
Doe, Jane	$1690.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1690.00	11/2018
Doe, John	$ 34.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ 34.68	11/2018
Monthly Subtotal:	$1724.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1724.68	
Voucher Total	$3579.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3579.36	

SAMPLE

Missouri Kidney Program Application Renewal Form

Please review the pre-printed information, make any changes or corrections.

Name:	«fname» «mname» «lname» «patno»	______________________________
Address:	«addr1»	______________________________
	«addr2»	
	«city», «state» «zip»	______________________________
Phone Number:	«phone»	______________________________
County:	«cnty»	______________________________
Social Security #:	«ssn»	______________________________
Date of Birth:	«birth»	______________________________
Medicare Number:	«careno»	______________________________
Effective Date:	«caredate»	______________________________

PLEASE PROVIDE THE FOLLOWING INFORMATION:

MEDICARE Number: _________________ MO HEALTHNET Number:_________________________

Additional Insurance Coverage?

____

Please enclose a copy of the front and back sides of all insurance cards.

Please list the names of the people living in your household.

____

Please provide documentation of current household income, including social security, pension, disability, veteran benefits, unemployment, AFDC, Workman's Compensation, interest and any additional income sources. If you file taxes, send a copy of your most recent Federal Income Tax Return (1040) including all attached schedules, along with the W-2 form. Please also include a copy of your most recent Missouri State tax return and attached schedules.

Please list current balances for the following assets:

Checking Account(s)	$_________________	Savings Account(s)	$_________________
CD's/IRA's	$_________________	Stocks/Bonds	$_________________
Others (Please list)	_____________________________________		$_________________

Please send copies of current bank statements for these accounts.

Comments:

____

____

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____ ________________________

Patient signature **date**

______________-- ______ -- ________________ __________________________

SAMPLE