



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, C202
Columbia, MO 65211

Local: 573.882.2506
Toll Free: 800.733.7345
Fax: 573.882.0167

Email: UMHSmokpinfo@health.missouri.edu
Web: <https://mokp.org>

The manual is available online. We encourage you to bookmark and share this site with your staff and colleagues for future reference.

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Chapter 1	Section 010
General and Administrative Information	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.

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Chapter 1	Section 020
General and Administrative Information	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.

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Chapter 1	Section 030
General and Administrative Information	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.

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Chapter 1	Section 035
General and Administrative Information	Monthly Reimbursement Schedule

Data Entry Period (Request for Reimbursement)	Service Month (the month the service occurred)			MoKP issues check to facility
July 1, 2023- July 19, 2023	May 2023	June 2023	July 2023	July 25, 2023
July 24, 2023- August 16, 2023	June 2023	July 2023	August 2023	Aug 22, 2023
August 21, 2023- Sept 20, 2023	July 2023	August 2023	Sept 2023	Sept 26, 2023
Sept 25, 2023- October 18, 2023	August 2023	Sept 2023	Oct 2023	Oct 24, 2023
October 23, 2023- Nov 15, 2023	Sept 2023	Oct 2023	Nov 2023	Nov 21, 2023
Nov 20, 2023- December 20, 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2, 2024
December 26, 2022 - January 17, 2024	Nov 2023	Dec 2023	Jan 2024	Jan 23, 2024
January 22, 2024- February 21, 2024	Dec 2023	Jan 2024	Feb 2024	Feb 27, 2024
February 26, 2024 - March 20, 2024	Jan 2024	Feb 2024	Mar 2024	March 26, 2024
March 25, 2024- April 17, 2024	Feb 2024	Mar 2024	April 2024	April 23, 2024
April 22, 2024- May 15, 2024	March 2024	Apr 2024	May 2024	May 21 ,2024
May 22, 2024- June 19, 2024	April 2024	May 2024	June 2024	June 25, 2024

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

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Chapter 1	Section 035
General and Administrative Information	Monthly Reimbursement Schedule

Put another way --

You have from:	To be reimbursed for services performed in:
July 1, 2023 to July 19, 2023	May, 2023
July 1, 2023 to August 16, 2023	June, 2023
July 1, 2023 to September 20, 2023	July, 2023
August 1, 2023 to October 18, 2023	August, 2023
September 1, 2023 to November 15, 2023	September, 2023
October 1, 2023 to December 20, 2023	October, 2023
November 1, 2023 to January 17, 2024	November, 2023
December 1, 2023 to February 21, 2024	December, 2023
January 1, 2024 to March 20, 2024	January, 2024
February 1, 2024 to April 17, 2024	February, 2024
March 1, 2024 to May 15, 2024	March, 2024
April 1, 2024 to June 19, 2024	April, 2024
May 1, 2024 to June 19, 2024	May, 2024
June 1, 2024 to June 19, 2024	June, 2024

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

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Chapter 1	Section 040
General and Administration Information	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.

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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>

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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 C202

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 \$2,000/month are eligible for MoKP based on income and asset requirements.

SPEND DOWN (LIMIT):

Spend Down maximum = \$2,000/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 \$2,000

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.

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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, 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 Parts A and B. If Medicare is not active, the CMS Form 2728 is required with the MoKP application. If approved for Medicare, the participant must maintain active coverage for Medicare Parts A and B.

If Medicare closes due to no longer being deemed disabled, then the program will work with the participant to find alternate coverage.

If Medicare Part B closes due to non-payment of premiums, then the program will work with the participant to reapply for Part B during General Enrollment or using Medicare Savings Programs. Failure to maintain Part B insurance coverage may result in termination of assistance through MoKP.

MEDICARE PRESCRIPTION COVERAGE:

Medicare prescription coverage must be maintained to remain on the program. MoKP will send each participant on the Centralized Drug Program (CDP) a consent form before Open Enrollment every year. This consent form will authorize MoKP to enroll a participant into 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 prior to enrolling in the plan.

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Chapter 2	Section 030
Eligibility Criteria	Other Requirements

PRIVATE/GROUP MEDICAL INSURANCE

MoKP participants/social worker should notify the program when coverage with any Private/Group Medical insurance changes including Employee Group Health Insurance, Medicare Supplements, etc. A creditable drug coverage letter is required when a private/group health insurance is active for a participant on the CDP.

Failure to maintain insurance coverage may result in termination of assistance through MoKP.

If a participant on the CDP no longer has Medicare and/or Medicaid and has access to a private/group health insurance, they should enroll in the available coverage. MoKP is payor of last resort.

MOKP PHARMACY USAGE

All MoKP formulary medications should be obtained through the MoKP contracted pharmacy to maintain assistance through the CDP. The MoKP medication formulary is located through the MoKP Database or through the public website. Many over-the-counter medications are included in the formulary and should be obtained through the MoKP CDP. Only controlled substances or short-term drug therapies should be obtained from a local pharmacy.

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Chapter 2	Section 035
Eligibility Criteria	MoKP Income/Assets Eligibility Chart (based on 2024 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 \$2,000

MoKP Income Eligibility (250%FPL)		
Dependents	Annual	Monthly
1	\$37,650	\$3,138
2	\$51,100	\$4,258
3	\$64,550	\$5,379
4	\$78,000	\$6,500
5	\$91,450	\$7,621
For each add'l dependent add	\$13,450	\$1,121

ASSETS GUIDELINES:

Asset Limit is \$15,000 regardless of the number of dependents.

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Chapter 2	Section 040
Eligibility Criteria	Annual Reviews

Annual Reviews:

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. During the review, assistance program usage is reviewed. If the participant is not actively using the approved assistance, then coverage may be terminated.

Participant signatures will be required on the Participant Agreement and Medicare Part D Enrollment and/or Medicare Advantage Confirmation forms annually. These forms will be sent out every June/July with notification to the social worker listed for each participant.

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Chapter 3	Section 010
Application for MoKP Assistance	Application Process Overview

APPLICATION PROCESS

The dialysis and/or transplant social worker will submit an application for MoKP assistance through an online portal or using a paper application (available on the secure MoKP database). Online applications are preferred. Applications will be reviewed by MoKP within 20 days of receipt.

Paper application can be submitted to:

Email: umhsmokpinfo@health.missouri.edu

Fax: 1-573-882-0167

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

The application form requires the following information:

1. Demographic information
2. Medicare, MO HealthNet and other insurance information including copies of all insurance cards, if available
3. Types of assistance requested
4. Participant Agreement Form (MoKP 107a) must be signed by the applicant
5. If the applicant is requesting assistance with medications and/or immunosuppressants, prescriptions will need to be sent to Kilgore's in one of the following ways:
 - a. Prescription Order Form (MoKP 103) sent directly to Kilgore's Fax at 573-443-4754
 - b. Escrip to Kilgore's located at 700 N Providence Rd, Columbia, MO 65203
 - c. Kilgore's to transfer the prescriptions over from another pharmacy. Need name and phone number of the other pharmacy.
6. If the applicant is requesting assistance with transportation, then the roundtrip mileage estimation or vendor quotes will need to be included. The paper application has the Transportation Form (MoKP 115).
7. If MO HealthNet eligibility requirements are not met, then Income and Assets Information (MoKP 107) must be completed.

Supporting documentation must be provided for the application to be considered complete. MoKP reserves the right to reject an application if supporting documentation is not submitted within 20 days. Please see Chapter 2 to review the Eligibility Requirements.

Note: The participant's assigned social worker will receive copies of all MoKP communications.

MoKP should be notified of any of the following change:

- income
- insurance coverage including Medicare or MO HealthNet

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Chapter 3	Section 010
Application for MoKP Assistance	Application Process Overview

- mailing address and/or physical address
- phone number
- transfer to another facility including to another dialysis center, rehab facility, lengthy hospitalization, etc,
- received a kidney transplant
- participant expires

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Chapter 3	Section 020
Application for MoKP Assistance	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 \$2,000
- Ticket to Work Health Assurance (TWA) 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.*

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Chapter 3	Section 030
Application for MoKP Assistance	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 for Missouri Kidney Program Assistance

Participant Information = Name, Gender, Address, County, Telephone Number, Cell Phone Number, Email Address, Social Security Number, Date of Birth, Marital Status, Number of Dependents, Race

- **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.
- **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.

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.**

- **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.**

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.

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Chapter 3	Section 030
Application for MoKP Assistance	Participant Application

- **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 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.

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.

Other Documentation = documents needed for specific types of requested assistance

1. Transportation Assistance
 - a. Mileage and Public Transportation Form (MoKP Form 115)
2. Routine medications
 - a. Prescription Order Form (MoKP Form 103) must be faxed directly to Kilgore’s Medical Pharmacy at 573-443-4754.
3. Immunosuppressant Medications
 - a. Prescription Order Form (MoKP Form 103) must be faxed directly to Kilgore’s Medical Pharmacy at 573-443-4754.
4. Insurance Premium Reimbursement
 - a. Provide invoice showing plan’s monthly premium
 - b. Provide front and back copy of insurance card

PAGE TWO:

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.

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Chapter 3	Section 030
Application for MoKP Assistance	Participant Application

PAGE THREE:

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 FOUR:

MoKP Transportation Form (MoKP Form 115)

If the applicant is needing transportations assistance, this form must be completed by the social worker and faxed to 573-882-0167.

Mode Requested

Mileage for private vehicle = list total miles (daily round trip)

Public Transportation (Share-A-Fare, Call-A-Ride, or City Bus Pass) = List total cost (daily round trip)

Vendor Transportation = must submit two quotes. You must verify mileage and public transportation are not appropriate for this participant

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

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Chapter 4	Section 010
Patient Assistance through Facility Reimbursement	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.

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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 the 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 the Transportation Form (MoKP Form 115). 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 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.

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Chapter 4	Section 020
Patient Assistance through Facility Reimbursement	Transportation Reimbursement

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.

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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.

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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.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

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

MoKP Facility Guidelines Manual

University of Missouri-Columbia

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	Section 010
Transplant Assistance Reimbursement	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.
4. MoKP offices will send the reimbursement recipient a letter explaining the program benefit along with an opportunity to provide a gratitude response.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 6	Section 020
Transplant Assistance Reimbursement	Example Letter

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 and current mailing address of person(s) receiving the funds (can be split between kidney donor and transplant recipient).
- 2) Confirm that transplant recipient is a resident of Missouri. Living donor does NOT have to be a resident.
- 3) Date of transplant.
- 4) Summary of the need for the funds. This assistance is NOT income/asset based.
- 5) Please send request letter on facility **letterhead** and send [secure] to Laurie Hines via email. hineslau@umsystem.edu or hineslau@health.missouri.edu

Sincerely,

Transplant Social Worker
Facility Name
Address
phone or email

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 010
Forms and Examples	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 102:	MoKP Application
MoKP Form 103:	Prescription Order Form – Kilgore’s Pharmacy
MoKP Form 107:	Income and Asset Information
MoKP Form 107a:	MoKP Participant Agreement
MoKP Form 109:	Transplant Update Form
MoKP Form 115:	Transportation Form
MoKP Form 116:	Transportation Reimbursement Verification
MoKP Form 117:	Consent for Medicare Part D PDP Enrollment
MoKP Form 117a:	Consent for Medicare Part D PDP Enrollment for NON-MOKP patient
MoKP Form 117b:	Medicare Advantage Confirmation

MoKP Participant Application (MoKP Form 102)

**MUST BE LEGIBLE • ANY MISSING INFORMATION WILL DELAY PROCESSING
ATTACH COPY OF ALL INSURANCE CARDS (FRONT AND BACK)**

Name: _____ Gender: ☐ Male ☐ Female
Use Full Legal Name, No Nicknames

Address: _____
Street/ Route #/ P.O. Box City Zip Code

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

Email address: _____

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Marital Status (check one): ☐ Married ☐ Single Number of Dependents (including applicant) _____

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

Medicare #: _____

If not eligible for Medicare, indicate reason _____

MO HealthNet # _____ Is the applicant eligible for military benefits? ☐ Yes ☐ No
Is the applicant receiving blind pension benefits? ☐ Yes ☐ No

Other Insurance _____

Type of Coverage: ☐ Medicare Supplement/Medigap ☐ Employer Group ☐ Private/Personal

CURRENT STATUS: ☐ Dialysis ☐ Transplant

If dialysis: date of first dialysis at current facility ____/____/____

If transplant: date of current transplant ____/____/____

TYPE OF ASSISTANCE REQUESTED:

☐ Transportation Reimbursement – available for trips to/from dialysis/dialysis training only
Include Transportation Form (MoKP 115)

☐ Routine Medications
Fax Prescription Order Form (MoKP 103) to Kilgore's Pharmacy at 573-443-4754

☐ Immunosuppressant Medications
Fax Prescription Order Form (MoKP 103) to Kilgore's Pharmacy at 573-443-4754

☐ Insurance Premium Reimbursement – available for transplanted participants only
Provide invoice showing plan's monthly premium
Provide front and back copy of insurance card

Print Social Worker Name

Facility Name

Fax completed forms to 573-882-0167

MoKP Prescription Order Form (MoKP Form 103)

Date: _____

To: Kilgore's Medical Pharmacy Fax #: 573-443-4754

Phone Numbers: Toll Free (866) FIL-MOKP (345-6657) Local 573-443-8556

From 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.)

Patient's Address: _____ (street – no PO boxes)

_____ (city, zip)



**Must be faxed directly to Kilgore's
Medical Pharmacy at 573-443-4754.**



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 \$2,000/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.	_____	_____	SELF	\$ _____
	Name	Age	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.**

MoKP Participant Agreement (MoKP Form 107a)

Please read, sign and date, and return promptly. An agreement must be signed every year before any assistance can be approved. Fax completed forms 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 make changes to my Medicare Part C or 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, disability, or status as a protected veteran.



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.

MoKP Transportation Form (MoKP Form 115)

This form must be completed by the Social Worker.
Fax completed forms to 573-882-0167

Patient Name: _____ Date ____/____/____
PLEASE PRINT

Facility Name: _____ Social Worker: _____

Mode requested (check one)

☐ **Mileage for private vehicle:** total miles _____ (daily round trip)
Rate = \$0.65 per mile

☐ **Public Transportation:** (\$ = round trip)

☐ Share-A-Fare \$ _____ (daily round trip)

☐ Call-A-Ride \$ _____ (daily round trip)

☐ City Bus Pass \$ _____

☐ **Vendor Transportation:** Must submit two quotes. You must verify mileage and public transportation are not appropriate for this participant.

Quote 1: Vendor _____ \$ _____ (daily round trip)

Quote 2: Vendor _____ \$ _____ (daily round trip)

Justification for Vendor Transportation:

Social Worker Signature

_____/_____/_____
Date

FOR OFFICE USE ONLY:

Effective Date: _____

Approved monthly cap: _____



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 \$0.65): _____

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: _____

MoKP Consent for Medicare Part D Enrollment (MoKP Form 117)

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: ____/____/____

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.

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:



Missouri Kidney Program

University of Missouri Health

CLAIM Consent for Medicare
Part D Enrollment

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)

Please select from the following race/ethnic origins:

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

Name of Pharmacy you use _____ Zip Code of the Pharmacy _____

- Attach a list of all medications that you take, including the dose and the frequency that you take the medication.
- Do you receive Social Security Disability? _____ Yes _____ No
- In order to determine if you are eligible for assistance with the cost of the premiums and copays through LIS (Low Income Subsidy) please mark the range of household income.
_____ If single, Below \$1,615 per month _____ If married, Below \$2,175 per month
_____ If single, Above \$1,615 per month _____ If married, Above \$2,175 per month
- I authorize the Missouri Kidney Program to review my personal information and make recommendations concerning Part D plans (Prescription Drug Plans) that meet my medication and medical needs.

Medicare # _____ Part A Eff. Date _____ Part B Eff. Date _____

Signature: _____ Date: _____

MoKP Medicare Advantage Confirmation (MoKP Form 117b)

Please complete the information listed here, attach a list of current medications, and select one option regarding your Medicare Advantage Plan.

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

Physical Address: _____

Mailing Address: _____

City: _____

Zip Code: _____ County: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of birth: ____/____/____

Current Policy: _____

Please select **one** option below:

- ☐ I want to remain in my current Medicare Advantage Plan with Prescription coverage. **I am responsible for ensuring all of my hospital, doctors, pharmacy and clinics are in network with this plan.**
- ☐ I want MoKP to change my coverage to Original Medicare with a Part D Prescription plan. **I have attached a complete list of my medications.**

Signature: _____ Date: ____/____/____

Guardian or Relationship if signing for patient: _____

FOR OFFICE USE ONLY:

MoKP#

Coordinator:

Social Worker:

Medicare #

Part A Date:

Part B Date

Comments:

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 020
Forms and Examples	Facility Agreement - Example

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). At the end of the current term, this Facility Agreement will renew annually unless either party gives 30 days notice of termination as required by paragraph 14 below.

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

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 020
Forms and Examples	Facility Agreement - Example

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 University if submitted by monthly voucher close date. 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.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 020
Forms and Examples	Facility Agreement - Example

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.

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.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 020
Forms and Examples	Facility Agreement - Example

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.

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-

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Chapter 7	Section 020
Forms and Examples	Facility Agreement - Example

507). Contract clauses required by the Government in such circumstances are incorporated herein by reference.

THE MISSOURI KIDNEY PROGRAM

By _____
Laurie Hines
Director

THE CURATORS OF THE UNIVERSITY OF MISSOURI UNIVERSITY

By _____
Sponsored Programs Administration

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

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 7

Forms and Examples

Section 030

Voucher by Patient Listing - Example



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
<i>Monthly Subtotal:</i>	\$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
<i>Monthly Subtotal:</i>	\$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	

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University of Missouri-Columbia

Chapter 7	Section 040
Forms and Examples	Application Renewal Form - Example

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:

Patient signature

date