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.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

Table of Contents

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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, 2024- July 17, 2024	May 2024	June 2024	July 2024	July 23, 2024
July 22, 2024- August 21, 2024	June 2024	July 2024	August 2024	Aug 27, 2024
August 26, 2024- Sept 18, 2024	July 2024	August 2024	Sept 2024	Sept 24, 2024
Sept 23, 2024- October 16, 2024	August 2024	Sept 2024	Oct 2024	Oct 22, 2024
October 21, 2024- Nov 20, 2024	Sept 2024	Oct 2024	Nov 2024	Nov 26, 2024
Nov 25, 2024- December 18, 2024	Oct 2024	Nov 2024	Dec 2024	Jan 7, 2025
December 23, 2024 - January 15, 2025	Nov 2024	Dec 2024	Jan 2025	Jan 21, 2025
January 20, 2025- February 19, 2025	Dec 2024	Jan 2025	Feb 2025	Feb 25, 2025
February 24, 2025 - March 19, 2025	Jan 2025	Feb 2025	Mar 2025	March 25, 2025
March 24, 2025- April 16, 2025	Feb 2025	Mar 2025	April 2025	April 22, 2025
April 21, 2025- May 21, 2025	March 2025	Apr 2025	May 2025	May 27 ,2025
May 26, 2025- June 18, 2025	April 2025	May 2025	June 2025	June 24, 2025

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

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, 2024 to July 17, 2024	May, 2024
July 1, 2024 to August 21, 2024	June, 2024
July 1, 2024 to September 18, 2024	July, 2024
August 1, 2024 to October 16, 2024	August, 2024
September 1, 2024 to November 20, 2024	September, 2024
October 1, 2024 to December 18, 2024	October, 2024
November 1, 2024 to January 15, 2024	November, 2024
December 1, 2024 to February 19, 2024	December, 2024
January 1, 2024 to March 19, 2024	January, 2025
February 1, 2024 to April 16, 2024	February, 2025
March 1, 2024 to May 21, 2024	March, 2025
April 1, 2024 to June 18, 2024	April, 2025
May 1, 2024 to June 18, 2024	May, 2025
June 1, 2024 to June 18, 2024	June, 2025

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

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 2 Eligibility Criteria	Section 040 Reviews/ Renewals

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. Income or MO HealthNet status changes may trigger a review to determine whether the participant continues to meet eligibility criteria.

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.

AUTO RENEWAL
Active MoKP participants with one of the following categories of MO HealthNet assistance do not require an Annual Renewal Application Form to be completed, nor do they need to submit income and asset information.

- MHABD Non-Spend Down
- MHABD Spend Down under $2,000
- 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 Section 040. 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.*

MoKP Facility Guideline Manual
University of Missouri-Columbia

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 MoKP Participant Application can be completed through an online platform in the MoKP Database or is available as a paper application in the Forms Menu.

Applications will not be processed until all required information and documentation is received. The Participant Agreement Form (MoKP Form 107a) must be signed and submitted.

Tips and tricks for completing the application:

- Online application is preferred. If completing a paper application, the writing needs to be legible.
- If they differ, we need both the physical and mailing address for the participant.
- Number of dependents includes the applicant plus a spouse and children who live with them and/or anyone on the same federal income tax return if they file one. If they do not file a tax return, remember to still add family members who live with them.
- If the participant is receiving Blind Pension, income and asset documentation must be attached with the application.
- When applying for medication assistance, we need to know of all of the participant's insurance coverage. Attach all available cards – copies of both front and back.
- When listing the date of first dialysis, we need the first date of dialysis at the current facility.
- When applying for transportation reimbursement, the MoKP Transportation Form (MoKP Form 115) must be submitted.
- When applying for routine and/or immunosuppressant medication assistance, prescriptions must be submitted to Kilgore's Medical Pharmacy. These can be sent using the Prescription Order Form (MoKP Form 103) faxed directly to Kilgore's Medical Pharmacy at 573-443-4754. The prescriptions can also be e-scripted to Kilgore's.
- Do not fax the Prescription Order Form to MoKP offices.

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.

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 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.

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.

MoKP Facility Guidelines Manual

University of Missouri-Columbia

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.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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 $500 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 $500.
- 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.

Chapter 6	Section 020
Transplant Assistance Reimbursement	**Example Letter**

DATE

Lisa Parnell, MSW, LCSW
Missouri Kidney Program
2800 Maguire Blvd, Ste C202
Columbia, MO 65211
RE: Transplant Donor Assistance

Dear Ms. Parnell:
I am requesting transplant assistance reimbursement in the amount of $_____ ($500 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 Lisa Parnell via email. lparnell@missouri.edu

Sincerely,

Transplant Social Worker
Facility Name
Address
phone or email

MoKP Facility Guidelines Manual
University of Missouri-Columbia

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 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)**

Kilgore's Medical Pharmacy

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**

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.

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: _____

Missouri Kidney Program
University of Missouri Health

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 $0.65): _____

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:

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

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.

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.

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-

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

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	

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**

_____-- _____ -- _____ _____