Missouri Kidney Program
University of Missouri Health

Facility Guidelines Manual

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

Requests, Suggestions and Comments may be addressed to:

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

Local: 573.882.2506
Toll Free: 800.733.7345
Fax: 573.882.0167

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

The manual is accessible 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

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

- **Mission**
  The Missouri Kidney Program 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

The MoKP Advisory Council approves an annual operating budget and a facility agreement is executed between each facility and MoKP through the Curators of the University of Missouri. The agreement is explained in the following pages.

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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 MO 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.

- 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 1 General and Administration; Section 025 to review a 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).

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

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

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

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

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

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

APPENDIX I

Facility: «FACNO»

SPOC: «FacSpoc»

MOKP FACILITY AWARD Assistance Guidelines FY «NextYear»

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

ASSISTANCE

Centralized Drug Program

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

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

Transportation Assistance

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

Premiums

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

Immunosuppressive Drug Co-Pays

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

Transplant Assistance Program

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

Missouri Kidney Program APPENDIX II
Monthly Voucher Reimbursement Schedule
FY 2020

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

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

Put another way --

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

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

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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:
Those with a userid and password to the Missouri Kidney Program database may login to print this report. 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.

Access to the MoKP database is limited to contracted facility social workers and billers.

Refer to Chapter 1 General and Administrative Information; Section 035 to review a 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
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	

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

MoKP reserves the right to perform random 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 in the participation in MoKP. This continues to be applicable in the event the facility discontinues as an active participant with MoKP.

The facility may randomly 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 government 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 1	Section 050
General and Administrative Information	**Payer of Last Resort**

MoKP requires all applicants and current participants to apply for and maintain Medicare, MO HealthNet, Medicare Supplement programs (Medigap), and/or private/group insurance (possibly through the spouse's employer) 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 is strongly urged to apply for the ACA/Marketplace plan in their area.

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

To qualify for MoKP assistance, individuals must meet certain 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 (nor 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 Eligibility Criteria	Section 020 MO HealthNet Requirements

All MoKP applicants/participants must have made application to MO HealthNet.

Applications for MO HealthNet for Aged, Blind & Disabled (MHABD) should be sent to the Family Support Division (FSD) Eligibility Specialist located at the MoKP administrative office in lieu of having the applicant apply at their local FSD county office. This will expedite the processing of the MHABD application.

MoKP/State FSD Eligibility Specialist Phone: 1-866-665-7373, Fax: 1-573-884-5276

MHABD applications are available through the social worker access to the Missouri Kidney Program website at https://mokp.missouri.edu/mokp_web/ or at https://mydss.mo.gov/healthcare/mo-healthnet-for-people-with-disabilities

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 SpendDown not exceeding $1,200/month are eligible for MoKP based on income and asset requirements.

SPENDDOWN (Limit):
Spenddown maximum = $1,200/month.

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

MO HealthNet Blind Pension
MO HealthNet for Children and/or Families
MO HealthNet spenddown cases over $1,200

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

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Chapter 2	Section 030
Eligibility Criteria	Other Requirements

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

INCOME GUIDELINES:
For persons not eligible for MO HealthNet, eligibility will be based on the household income and assets. Please see 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 Missouri Kidney Program applicants of assistance must have made application for Medicare Part A, and/or Part B and Part D. If approved for Medicare, the participant must maintain active coverage for Medicare Part A, and/or Part B and Part D.

MEDICARE PART D COVERAGE:
If a person has Medicare Parts A and/or B, then they are eligible to enroll in a Medicare Part D plan. MoKP requires participants, who are receiving medication assistance, to enroll in a Medicare Part D plan. At the time of application, a Medicare Part D Enrollment Consent form requires the participant's signature. The participant must complete this consent annually to remain active on the program. The consent will authorize MoKP coordinators to enroll a participant in a Medicare Part D plan appropriate to their needs. Unless notified by the Missouri Kidney Program coordinator, the Medicare Part D plan will be a dual eligible plan with $0.00 monthly premium.

There are participants who have primary coverage other than Medicare. In some of these cases, participants must use that prescription coverage offered through their primary coverage rather than a Medicare Part D plan. These participants will have an exemption from this requirement.

Chapter 2	Section 030
Eligibility Criteria	Other Requirements

MEDICARE ADVANTAGE PLANS:
MoKP will not provide medication assistance for persons enrolled in Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plans.

MA/MAPD plans increase the financial liability for MoKP compared to original Medicare with or without a Medicare Supplement Plan and/or Mo HealthNet for the following reasons:

- The financial liability affects the participant, medical facility and MoKP not only in the cost of medications and immunosuppressants, but also in a limited formulary.
- These plans do not allow use of a participant's incurred medical charges to meet their MoHealthNet spenddown
- MA/MAPD plans also limit access for the person to specific providers and pharmacies.

If a MoKP participant becomes enrolled in a MA/MAPD plan while receiving medication copay assistance, the MoKP Coordinators will investigate the circumstance. This will include consulting with the facility social workers to provide guidance for the beneficiary regarding the best third party payer coverage for both the beneficiary and MoKP's benefit.

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

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

COMPLIANCE TO PHARMACY
Only controlled substances or short-term drug therapies should be obtained from a local pharmacy. All other medications should be obtained through the contracted pharmacy to maintain MoKP assistance.

In the situation in which the person must use a specialty pharmacy, MoKP is unable to assist with these medications. Examples: some private insurance plans require the person use a specific mail order pharmacy or specialty pharmacy for certain medications.

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Chapter 2	**Section 035**
Eligibility Criteria	**MoKP Income/Assets Eligibility Chart (based on 2019 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 spenddown over $1,200

Routine Medications (150% of FPL)		
Dependents	**Annual**	**Monthly**
1	$18,735	$1,561
2	$25,365	$2,114
3	$31,995	$2,666
4	$38,625	$3,219
5	$45,255	$3,771
For each add'l dependent add	$6,630	$553

Private Insurance Premiums (175%FPL)		
Dependents	**Annual**	**Monthly**
1	$21,858	$1,821
2	$29,593	$2,466
3	$37,328	$3,111
4	$45,063	$3,755
5	$52,798	$4,400
For each add'l dependent add	$7,735	$645

Immunosuppressant Medications (250%FPL)		
Dependents	**Annual**	**Monthly**
1	$31,225	$2,602
2	$42,275	$3,523
3	$53,325	$4,444
4	$64,375	$5,365
5	$75,425	$6,285
For each add'l dependent add	$11,050	$921

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

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

ASSISTANCE PERIODS:

MoKP applicants are generally approved for one-year periods contingent on maintaining Medicare, third party insurances, and MO HealthNet as applicable. Annual reviews are conducted and approvals are extended in one-year increments providing MO HealthNet coverage is maintained appropriately and/or there are no significant income/asset changes. An "approval letter" is sent to the participant and social worker with the dates of the participant's assistance period.

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

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Chapter 3	Section 010
Application for MoKP Assistance	**Application Process Overview**

EFFECTIVE 07-01-2011:

- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients **not actively** using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

Persons wishing to be considered for assistance from the MoKP must complete an application for MoKP Assistance and provide requested supporting documentation. The social worker and patient will complete the application and mail it to the MoKP. Faxed applications are not accepted. Social worker and patient signatures must be original.

The application contains the following:

- Demographic information
- Medicare, Mo HealthNet and other insurance information
- Diagnosis information
- Type of assistance requested, including a justification for funding which must be signed by the social worker
- Income/Asset information which must be submitted if the potential patient is not eligible for one of the following 3 categories:
  - MO HealthNet for the Aged, Blind and Disabled (MHABD) Continuous
  - MHABD spenddown under $1,200
  - Ticket to Work Health Assurance (TWHA) Program
- Patient Release form which must be signed by the patient

Applications may be obtained by the social worker at a MoKP contract facility by contacting the MoKP office:

Missouri Kidney Program
AP Green Building – Suite 111
201 Business Loop 70 West
Columbia, MO 65211-8180
1-800-733-7345

The social worker will forward the completed application, including required documentation to the MoKP for determination of the individual's eligibility for assistance.

Chapter 3	Section 010
Application for MoKP Assistance	**Application Process Overview**

Applications will be reviewed by the MoKP Coordinators in the first 20 days of receipt. If the application is complete and/or MO HealthNet status is active and all requirements are met, the patient will receive a MoKP Award Letter. Copies of the letter will be sent to the facility social worker.

NOTE: *Social workers will receive copies of all communications MoKP has with the patients.*

Applications cannot be processed until all requested information and documentation is received. The social worker will be contacted to request any missing information or documentation. If the requested information is not received, the MO HealthNet application is not complete or is denied, etc., the application will be terminated.

Patients are awarded approval for assistance typically for one-year periods.

MoKP PATIENT FILE MAINTANACE INFORMATION:
Changes in income, insurance coverage, MO HealthNet status, Medicare status or residence must be forwarded to MoKP by patient and/or social worker.

Facility staff is required to notify MoKP staff of patient transfers between facilities. **It is <u>not</u> necessary to complete another application for those patients who transfer from one facility to another; please notify MoKP immediately, either in writing or by telephone.**

MO HEALTHNET PROXY:
MO HealthNet eligibility requirements are more stringent than MoKP eligibility requirements, therefore, in order to reduce paperwork and workload for the facility and MoKP personnel, MO HealthNet eligibility will be accepted as a proxy for proof of MoKP eligibility in the following categories:

- MHABD Continuous
- MHABD spenddown under $1,200
- Ticket to Work Health Assurance (TWHA) Program

For non-MO HealthNet eligible applicants or MO HealthNet assistance other than the 3 above categories above income/asset eligibility requirements will be followed.

ANNUAL RENEWAL PROCESS:
The following is for patients NOT in one of the following categories i.e. not eligible to be automatically approved for MoKP assistance another 12 months:

- MHABD Continuous
- MHABD spenddown under $1,200
- Ticket to Work Health Assurance (TWHA) Program

Chapter 3	Section 010
Application for MoKP Assistance	**Application Process Overview**

Annually, the patient not auto-enrolled for another year due to MO HealthNet eligibility will be mailed a Renewal Application Form along with a letter containing instructions for completion. These patients will be required to complete and return to MoKP the annual Renewal Application Form and the requested documents including but not limited to; current income, assets, and current insurance information. Facility social workers will receive copies of correspondence sent to patients regarding the update. If the patient exceeds MoKP guidelines the patient and social worker will be contacted.

Applicants with one of the 3 following categories of MO HealthNet assistance:

- MHABD Continuous
- MHABD spenddown under $1,2 00
- Ticket to Work Health Assurance (TWHA) Program

Patients in one of the 3 above categories do not require an Annual Renewal Application Form to be completed nor do they need to submit income and asset information. These patients 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 patient continues to meet eligibility criteria.

NOTE: *Approval by the MoKP Coordinator for financial assistance is always contingent on continued availability of funds to the MoKP and/or as budgeted through the renal facility.*

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Chapter 3	Section 020
Application for MoKP Assistance	**Paper Application**

EFFECTIVE 07-01-2011:

- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients **not actively** using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

The patient should complete the MoKP application with assistance from the facility social worker. All blanks should be completed or N/A written to indicate this information does not apply. **Incomplete applications will be held until all requested information and documentation is received.**

NOTE: *Social worker and patient signatures must be original-not copies.*

An application is included in this section for reference. Following is a description of information requested:

PAGE ONE: (this page is to be completed by the patient and/or the social worker)
Name = use full legal name with middle initial, no nicknames

Sex = check male or female

Permanent Address = the permanent address where the patient resides. Street/Route #, City, State and Zip Code must all be listed for the patient. If the patient 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 that patient'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 a patient. If this is the case, please note the patient's address, and then also note the name, relationship and address of the person responsible for processing mail.*

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

Telephone number, including area code = patients phone number. If the patient does not have a telephone, please note a contact person-name, relationship and phone number. *Include mobile phone numbers when possible.*

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Application for MoKP Assistance	**Paper Application**

Social Security Number = the nine digit social security number

Date of Birth = Month, Day, Year

Marital Status = check married or single

Number of Dependents, including yourself = number of dependents claimed on the patient's tax return (which does include self)

Ethnic Origin = circle ethnic origin

Medicare Number = the number, including the alpha character, from the patients Medicare card. *A copy of the card is very helpful.*

Effective Date (Part B) = the effective date of part B as shown on the card.

If not eligible for Medicare, indicate reason = list the reason the patient does not have and/or is not eligible for applying for Medicare.

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

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

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

MC+ Assistance for Families benefits = is the patient receiving MC+ or Assistance for Families – check yes or no. If the patient is receiving MC+ or Assistance for Families, income and asset documentation must be attached.

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

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

PAGE TWO: (this page is to be completed by the social worker)

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

Type of Assistance Requested = check all requested assistance.

Routine Meds - attach the Prescription Order Form (MoKP Form 103), and the Consent for Medicare Part D Enrollment (MoKP Form 117).

Immunosuppressants - attach the Prescription Order Form (MoKP Form 103), and the Consent for Medicare Part D Enrollment (MoKP Form 117)

Insurance Premiums: Private - write in the requested $ amount and attach supporting documentation.

Justification for funding = a detailed justification for funding is required. The justification should include financial and physical need. Incomplete or inadequate justifications may delay processing of the application.

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

Social Worker Signature = Signature of social worker submitting the application. Illegible signatures may delay processing of the application.

Facility = Facility where this patient will be followed.

PAGE THREE: (this page is to be completed by the patient and/or social worker)

NOTE: *This page should be completed unless the patient is eligible for medical assistance through MO HealthNet coverage in one of the following categories:*

- MO HealthNet for the Aged, Blind & Disabled (MHNABD) Continuous,
- MHNABD spenddown under $1,200
- Ticket To Work Health Assurance (TWHA) Program.

Income Eligibility **=** For purposes of eligibility, MoKP considers the income of all dependents or individuals living in the household, including the applicant, who are either supported by the applicant or who are contributing to the support of the household where the applicant resides.

If the applicant files taxes, MoKP uses the income reported and the number of dependents claimed on the applicant's tax return. If the applicant does not file taxes but is claimed as a dependent by another, MoKP uses the income and number of dependents claimed on the tax return of the person who is claiming the applicant as a dependent.

If the applicant claims no current income stream MoKP considers the income stream of the person who is providing for or residing with the applicant.

If the applicant or the person who is providing support did not previously file taxes then three consecutive pay stubs of all household members may be used to determine eligibility.

To determine eligibility, an applicant must provide documentation of the income stream.

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Application for MoKP Assistance	**Paper Application**

Assets **=** The MoKP asset limit for purposes of eligibility is $15,000 per household. Assets generally include all liquid assets and/or real property not the primary residence.

Enter the appropriate $ amount in each blank or write $0.00 if the patient does not have the noted account. Each _____ (blank) must be completed. The most recent account statements must be attached. Documents/statements required include but are not limited to checking account, savings account, CD/IRA, Stocks/Bonds/Mutual fund balances and any other monetary asset.

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

PAGE FOUR: (this page is to be completed by the social worker)

The social worker is required to circle the appropriate primary cause of renal failure – diagnosis.

PAGE FIVE: (this page MUST be signed by the patient)

Refer to Chapter 3 Application for MoKP Assistance; Section 050 Patient Agreement – Example.

The patient must read (or have read to), sign and date this page before the application will be processed.

PAGE SIX: This page is for notes/comments from the applicant, the social worker, and/or MoKP Coordinator.

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Chapter 3 Application for MoKP Assistance	Section 030 Online Application

EFFECTIVE 07-01-2011:

- Elimination of the nutritional supplement assistance.
- Elimination of transportation assistance.
- Elimination of Medicare premium reimbursement assistance.
- Elimination of any insurance premiums assistance to patients **not actively** using the Centralized Drug Program.
- Eliminating patient/staff education assistance.
- Reduction in transplant/living donor grants.
- Reduction in financial eligibility asset limit to $15,000.

Online applications are electronically completed by the social worker using his/her personal social worker User ID and Password access to the data base at **https://mokp.missouri.edu/mokp_web.** The social worker should have all of the needed information with him/her before beginning to complete the online application. The data base is set to time out at 20 minutes. ***After the 20 minutes expires, all data not submitted previously to the data base will be lost and the online application process must be initiated again.***

When the social worker enters the data base using their social worker User ID and Password the following screen is seen.

Facility Access Menu

Select the information you are interested in:

- (•) Patient Information
- ( ) New Patient Application
- ( ) MoKP Forms
- ( ) MoKP Drug Formulary
- ( ) Facility Guidelines Manual

Select **New Patient Application**.

Enter patient's Social Security number: **(format: xxx-xx-xxxx)**

Enter the Social Security number. If you enter a Social Security number that is already in the data base, one of 2 screens will appear:

1. The Social Security number you have entered belongs to an active patient in the MoKP data base

- If you are entering an application for a different patient, please determine the correct Social Security number for the patient, then enter the corrected number or begin the application again later.
- If this is the correct patient and Social Security number, contact your MoKP Coordinator.

This screen simply means that the Social Security number you entered is for a patient that is currently on MoKP. Call your MoKP Coordinator to make sure this patient is showing up in the data base as your patient.

2. The Social Security number you have entered belongs to a terminated patient in the MoKP data base:

- If you are entering an application for a different patient, please determine the correct Social Security number for the patient, then enter the corrected number or begin the application again later.
- If you are entering an application to re-activate a terminated patient, select the Continue function below.

The above screen copy shows that the patient applied at some time in the past for assistance but is currently not active/approved for assistance. You may choose the continue button to proceed.

Application For Missouri Kidney Program Assistance

Please Complete All Relevant Blanks - Required fields are indicated in red in the data base.

You must complete the form and exit this page within 20 minutes.

Name: First [ ] **Initial** [ ] **Last** [ ] **Sex** (•) **Male** ( ) **Female**

Address1 [ ] **Address2** [ ]

City [ ] **MO ZIP** [00000] **Phone (xxx-xxx-xxxx)** [ ]

Social Security number 514724066 **Date of Birth (mm/dd/yyyy)** [ ]

Marital Status (•) **Married** ( ) **Single** **No. of Dependents (including patient)** [ ]

Ethnic Origin [White]

Medicare # [ ] **Effective Date (Part B) (mm/dd/yyyy)** [ ]

Medicare Rx Start Date (mm/dd/yyyy) [ ]

Chapter 3	Section 030
Application for MoKP Assistance	Online Application

-- OR -- If not eligible for Medicare, indicate reason

MO HealthNet #

-- OR -- If not eligible for MO HealthNet, indicate reason

Is the patient or their spouse eligible for military benefits? Patient ☐ Yes ☒ No

Spouse ☐ Yes ☒ No

Is the patient receiving MC+ (AFDC) benefits? ☐ Yes ☒ No

Is the patient receiving a blind pension benefit? ☐ Yes ☒ No

Other Insurance (Leave blank if none)

Type of Coverage: (Select one)

☐ Medicare Supp./Medigap ☒ Employer Group ☐ Private/Personal ☐ Medicare Advantage

Policy No. **Group No.** **Phone No.**

Name of Policyholder **Effective Date**

Other Insurance Notes/Comments:

PATIENT CURRENT STATUS ☒ Dialysis ☐ Transplant

If dialysis, date of first dialysis at your facility (mm/dd/yyyy)

If transplant, date of current transplant(mm/dd/yyyy)

Type of transplant N/A or Unknown **(Required if transplant patient)**

Diagnosis: MoKP cannot establish eligibility without a diagnosis.

Diabetes Type II

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

TYPE OF ASSISTANCE REQUESTED

☐ **ROUTINE MEDICINES**
Eligibility for medicines begins on the date this application is approved by MoKP.

☐ **INSURANCE PREMIUMS: Private: $ per month**

☐ **IMMUNOSUPPRESSANTS**
Eligibility for medicines begins on the date this application is approved by MoKP.

JUSTIFICATION FOR FUNDING

(Justification should include both financial and socio-economic need)

Date: 7/21/2009 **Facility** Barnes Jewish Hospital Dialysis Center

Social Worker Signature: ***Cynthia Murray***

NOTE: *An online application worksheet (MoKP Form 101) must be received within 4 business days of submitting this form. All required documentation must be included with the form before this application can be approved.*

Online Application Definitions

Name = use full legal name, no nicknames

Sex = check male or female

Permanent Address = the address where the patient receives his/her mail. If the patient receives his/her mail at a PO Box, note that is the mailing address, but include in the comments the actual physical address where the patient resides. Street/Route #, City, State and Zip Code must all be listed for the patient. The patient's physical address is needed to verify that he/she is a resident of Missouri. It is helpful to include a piece of mail that the patient has recently received at the address he/she is currently living to verify correct address. 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 a patient. If this is the case, please note the patient's address, and then also note the name, relationship and address of the person responsible for processing mail in the justification section.

Telephone number, including area code = patient's phone number. If the patient does not have a telephone, please note a contact person—name, relationship and phone number in the justification.

Social Security Number = this number is entered from the previous screen

Date of Birth = Month, Day, Year

Marital Status = check married or single

Number of patient's dependents, including them self = number of dependents claimed on the patients tax return (which does include self)

Ethnic Origin = circle ethnic origin

Medicare Number = the number, including the alpha character, from the patient's Medicare card

Effective Date (Part B) = the effective date of part B as shown on the card using mm/dd/yyyy.

If not eligible for Medicare, indicate reason = list the reason the patient does not have and/or is not eligible to apply for Medicare.

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

If not eligible for MO HealthNet indicate reason = list the reason the patient has not applied for MO HealthNet or applied and was rejected. Submit a copy of the rejection letter.

Military benefits = is the patient or your spouse, eligible for military benefits – check yes or no. If yes, please submit a copy of the patient's TriCare or ChampVA card. If the patient is only eligible for assistance through the VA center itself, please note as such.

MC+ Assistance for Families benefits = is the patient receiving MC+ or Assistance for Families – check yes or no. If the patient is receiving MC+ or Assistance for Families, income and asset documentation must be submitted.

Blind Pension benefits = are you receiving blind pension– check yes or no. If the patient is receiving Blind Pension, income and asset documentation must be submitted.

Other Insurance = list all other 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.

Patient Current Status = check dialysis or transplant; for dialysis patients list the date of the first dialysis at your facility; for transplant patients list the date of the current transplant and circle

whether the transplant was a Cadaver (CAD), Living Related Donor (LRD) or Living Unrelated Donor (LUD).

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

Routine Medicines—submit the Prescription Order Form (MoKP Form 103) and the Consent for Medicare Part D Enrollment (MoKP Form 117).

Immunosuppressant-- submit the Prescription Order Form (MoKP Form 103) and the Consent for Medicare Part D Enrollment (MoKP Form 117)

Insurance Premiums: Private—write in the requested $ amount and submit supporting documentation.

Justification for funding = a detailed justification for funding is required. The justification should include both financial and socio-economic need. Incomplete or inadequate justifications may delay processing of the application.

Date = this is completed automatically by the computer with the current date.

Social Worker Signature = Social worker that is signed on to the data base using User ID and Password is automatically filled in.

Facility = Select from the drop down menu the facility where this patient will be followed.

After submitting the online application, the following screen is displayed. Print out this screen so you know what documents you need to submit.

Required Documentation:

In order to have this patient considered for the MoKP program, you will need to **mail the supporting documentation listed below within four business days.** You can view and print these forms in Adobe Acrobat (PDF) format by selecting the buttons on this page. You will need the free Adobe Acrobat Reader installed on your PC in order to view or print a form. If you do not have Reader installed on your PC it can be downloaded and installed from Adobe's Web site; click here to go to the download site.

Provide a copies of the patient's **Medicare, MO HealthNet and/or private insurance cards** (both front and back), plus the following forms:

- ☐ Missouri Kidney Program On-Line Application Worksheet (MOKP 101), signed by the social worker.
- ☐ Patient Agreement Form (MOKP 107a), signed by the patient.

- ☐ Income and Assets Information Form (MOKP 107) with supporting documentation as applicable.

If requesting medications assistance:

- ☐ Prescription Order Form (MOKP 103).
- ☐ Kilgore's Pharmacy Distribution Form.
- ☐ Consent for Medicare Part D PDP Enrollment (MOKP 117).

To view and/or print a form, select the form you are interested in and click on the Display Form button below. When the form has been displayed, you can print it using the Acrobat Reader Print button. Then return to this menu using your browser's Back button.

All documents as above must be submitted by mail with original signatures of the patient and social worker before the MoKP Coordinator can begin to process the online application.

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Chapter 4	Section 010
Patient Assistance through Facility Reimbursement	**Overview Statement**

OVERVIEW STATEMENT:
MoKP offers assistance, through contracts with dialysis facilities, for eligible Missourians with end stage renal disease and kidney transplant recipients. MoKP only pays on a reimbursement basis, to contracted facilities, never to patients or vendors directly.

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 assistance and the process for application.

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

Financial reimbursement for round-trip travel to the closest dialysis clinic facility is available to patients who meet MoKP eligibility criteria. The least expensive form of transportation appropriate for the patient should be used, 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

Transportation assistance is available for the round trip expense from the patient's home to the nearest dialysis clinic. For 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.

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

MILEAGE AND PUBLIC TRANSPORTATION PROCESS:
An MoKP Application for Assistance must be submitted to request transportation assistance including Mileage and Public Transportation Form (MoKP Form 115). When completing the form indicate the mode of transportation needed. If mileage reimbursement is requested, list the total numbers of miles for the round trip to and from dialysis. If the patient requires more than 14 dialysis trips per month, please note in the comment section the number of treatments the patient will have per month. A new request must be completed when there is a change in mode, cost, patient address or facility.

VENDOR TRANSPORTATION PROCESS:
An MoKP Application for Assistance must be submitted to request transportation assistance including a Vendor Transportation Form (MoKP Form 115a). If requesting vendor reimbursement, two written vendor quotes are required. If the patient requires more than 14 dialysis trips per month, please note in the comment section the number of treatments the patient will have per month. Vendor transportation requests will be reviewed by a committee made up of MoKP staff and MoKP Advisory Council members for the approval/denial process. A new request must be completed when there is a change in mode, cost, patient address or facility. All approved vendor transportation will be reviewed every three to six months to confirm continued need.

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

RECORDS RETENTION: If the social worker is reimbursing a patient for mileage, the Transportation Reimbursement Verification (MoKP Form 116) must be completed each month. The facility must keep the Transportation Reimbursement Verification and all original supporting documents from vendors for five years to meet MoKP audit requirements.

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

MoKP is committed to continuing transportation assistance, with some changes that will help the program better monitor and ensure its sustainability. Note there are two application forms based on the type of transportation assistance requested. The vendor transportation form requires written responses to questions that will guide the MoKP review and approval/denial process.

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

MoKP provides medication assistance through a contracted pharmacy.

Benefits of using the Centralized Drug Program (CDP) include but are not limited to:

1. Medications currently on the MoKP formulary are dispensed at no cost to the patient. Medication not on the MoKP formulary is billed to the patient by the contract pharmacy.
2. Medications are mailed to the facility or by prior approval to the patient's home (as per the instructions on the Prescription Order Form (MoKP Form 103).
3. MoKP staff will work with the contract pharmacy to manage enrollment in Medicare Part D Prescription Drug Plans (PDP) to ensure the least out-of-pocket expense.

To request Routine Medication and/or Immunosuppressant assistance for a patient the facility social worker must submit a completed Application for MoKP Assistance.

The Prescription Order Form (MoKP Form 103) must accompany the application when medicines or immunosuppressant assistance is requested. The form can be accessed from the forms menu of the Facility Access Menu. **Be sure to include any known allergies, address where medicines are to be mailed, and signed by appropriate medical personnel (i.e. physician, nurse practitioner, RN taking verbal order, etc.)**

If the patient is eligible or will be eligible in the future for Medicare, a Consent for Medicare Part D PDP Enrollment (MoKP Form 117) must be completed and signed before the MoKP Coordinator can approve the patient for the CDP.

After the MoKP Coordinator reviews the application and determines that the patient is eligible for assistance, an award letter is sent to the patient instructing them to call the contract pharmacy (the name and toll free phone number is provided) when they need their next refill.

The contract pharmacy does not mail medications until the patient or their representative calls the contract pharmacy to order refills. This prevents duplicate filling of meds, etc. Medication will be shipped through the least expensive method and facility mailings are strongly encouraged. The contract pharmacy decides the most efficient and cost effective method of shipping.

Following MoKP approval for assistance through CDP, the facility may communicate directly with the contract pharmacy to add or change prescriptions.

MoKP recommends the medications to be mailed to the dialysis facility for dialysis patients. This decreases shipping costs -- especially if several patients' medications can be shipped together. Dialysis facilities can also use this as an opportunity to review the medications patients are taking and assess compliance.

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

MO HEALTHNET:
The MoKP contract pharmacy must be designated as the primary provider for MO HealthNet coverage. If MO HealthNet locks a patient into another pharmacy (ie. MO HealthNet HMO plans and/or MC+), the MoKP contract pharmacy can no longer dispense his/her medicines. If a patient is eligible for MO HealthNet, they must maintain that eligibility at all times to continue to receive assistance through the CDP.

PRIVATE INSURANCE:
The MoKP contract pharmacy has contracts with most of the private insurance companies available to Missouri residents. However, there are a few that specify where the mediations must be dispensed. In these cases, the MoKP contract pharmacy cannot dispense medication and the patient cannot be approved for CDP. Examples include but are not limited to:

- Wal-Mart employees must purchase their medications at Wal-Mart.
- Some large hospital organizations require their insured employees and retirees to use their out-patient pharmacy,
- Several private insurance companies require a specialty or mail order pharmacy for routine medications and immunosuppressants.

If a patient is eligible to have private insurance through their employer, spouse's employer, COBRA benefits, etc., the patient must maintain that private insurance coverage while receiving assistance from MoKP. The social worker should discuss specific situations that might be considered an exception to this rule with their individual MoKP Coordinator.

CREDITABLE COVERAGE:
In order for MoKP to avoid compromising a patient's employee group health care coverage, MoKP requires a copy of a "Creditable Coverage" letter when the patient is approved for the CDP and each year thereafter between November and January.

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 affect if the patient would decide to enroll in a Medicare Part D and use it.

MEDICARE PART D:
The contract pharmacy bills Medicare Part D plans for medications dispensed to Medicare eligible patients. MoKP requires patients to allow MoKP staff to manage their Medicare Part D enrollments to ensure that the patient is enrolled in the plan that best meets his/her needs considering the individual drugs the patient is prescribed. MoKP Consent for Medicare Part

D (MoKP Form 117) must be completed and signed annually by all patients that are approved for the CDP and are Medicare eligible. Allowing MoKP to manage enrollment in Medicare Part D Prescription Drug Plans allows MoKP to offer assistance to more Missourians through cost savings incurred in ensuring that each patient has a PDP that covers most of their specific medications.

In preparation for open enrollment MoKP staff will mail pre-printed consent forms either to dialysis social workers or directly to transplant patients in the early fall. The patient is to review the information, make any necessary changes, sign the consent form and return to MoKP by the designated date. The consent form authorizes MoKP staff to work with the contract pharmacy to ensure each patient is enrolled in a Medicare Part D Prescription Drug Plan (PDP) which covers all medications at the lowest possible cost.

NOTE: *For Medicare eligible patients a copy of the signed consent form is required in order for the patient to be eligible for the CDP.*

MEDICARE ADVANTAGE PLANS:
MoKP prefers not to provide assistance for patients choosing to enroll/maintain enrollment in Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plans.

MA/MAPD plans increase the financial liability MoKP may experience compared to original Medicare with or without a Medicare Supplement Plan and/or MHN (Medicaid) for the following reasons:

- The financial liability affects the patient, medical facility and MoKP not only in the cost of medications and immunosuppressants, but also in a limited formulary.
- These plans do not allow a patient's incurred medical charges to meet their MHN spenddown. In turn this creates lack of access to MHN transportation and/or federal match dollars for transportation expenses funded through MoKP.
- MA/MAPD plans also limit access for the patient to specific providers and pharmacies.

If a patient becomes enrolled in a MA/MAPD plan the MoKP Coordinators will investigate the situation. Then consult with the facility social workers to provide guidance for the patient regarding the best third party payor coverage for both the patient and MoKP's benefit.

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

MEDICARE PART B:
The contract pharmacy bills Medicare Part B for immunosuppressants dispensed to Medicare Part B eligible patients. The patient must maintain Medicare Part B coverage if they are eligible while receiving assistance from MoKP.

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Chapter 5 Centralized Drug Program (CDP)	Section 020 CDP Eligibility/Process

EFFECTIVE 07-01-2011:

- Reduction in financial eligibility asset limit to $15,000.

In order to receive routine medicines and/or immunosuppressant coverage patients must complete the Application for Assistance.

All potential beneficiaries of the CDP must meet one of the following eligibility requirements:

1. MO HealthNet eligibility if spenddown less than $1,200 month.

For applicants not eligible for MO HealthNet, eligibility will be based on the patient's income and assets.

2. MoKP income/asset guideline for Routine Medications (150 of FPL):		
Dependents	**Annual**	**Monthly**
1	$16,335	$1,361
2	$22,065	$1,839
3	$27,795	$2,316
4	$33,525	$2,794
5	$39,255	$3,271.25
For each add'l dependent add	$5,730	$478

3. MoKP income/asset guideline for Immunosuppressant Medications(250% of FPL:		
Dependents	**Annual**	**Monthly**
1	$27,225	$2,269
2	$36,775	$3,065
3	$46,325	$3,860
4	$55,875	$4,656
5	$65,425	$5,452
For each add'l dependent add	$9,550	$796

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

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Chapter 5 Centralized Drug Program (CDP)	Section 030 CDP Formulary

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

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

The current formulary can be accessed on MoKP public website at URL http://som.missouri.edu/mokp/. Click on the ”Patient Assistance” tab in the menu. Click on the “View Formulary” button at the bottom of the page.

You may sort the formulary in one of two ways:

- Category
- Drug Name

Injectables -- except for Insulin -- are not covered by MoKP.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 6	Section 010
MO HealthNet Programs	**Spenddown Pay-In Program & Ticket to Work Health Assurance Program (TWHA)**

MO HealthNet Programs:
Spenddown Pay-In Program &
Ticket to Work Health Assurance Program (TWHA)

MoKP recognizes the medical and financial benefit for patients having monthly "first day-first dollar" MO HealthNet insurance coverage. In addition, there is an indirect financial benefit for continuous insurance coverage for our facilities, physicians, and MoKP. To determine eligibility, MoKP staff conducts a cost-benefit analysis by comparing the patient's premium costs to the expected medications expenses. This is a case-by-case review, and can be a month-to-month determination.

NOTE: *This is NOT a direct assistance category that can be requested by the patients or the facility social workers on the application. However, the patient must be actively using the Centralized Drug Program to be eligible for this benefit.* ***The number of patients and the dollar amount of the spenddown that are paid are strictly at the discretion of the MoKP's staff and budget.***

Once MoKP has made the decision to pay a MO HealthNet spenddown or TWHA premium, the payment process is completed one month in advance. MoKP sends a letter to the patient and the facility social worker each month notifying them that the payment is made, and there should be no interruption of their MO HealthNet coverage.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 7 **Transplant Assistance Program**	Section 010 **Transplant Assistance Overview**

EFFECTIVE 02-24-2012:

- Transplant grants increased to $1,000.
- A grant can be awarded for transplant expenses occurred up to 6 months after surgery.
- Insurance premium expenses previously covered by another organization. Example: Insurance premiums previously paid by American Kidney Foundation.

Transplant recipients or donors may be eligible for financial assistance to help defray out-of-pocket living expenses associated with transplantation. These recipients/donors do not have to be enrolled for MoKP assistance. A donor does not have to be a Missouri resident, but the kidney transplant recipient must be a Missouri resident.

To be considered for this type of assistance, the transplant facility social worker (or other transplant facility staff member) must submit a written request to the MoKP Director outlining the unusual financial circumstances involved.

If possible, requests should be submitted prior to the transplant surgery. MoKP will not reimburse the facility until the transplant has occurred.

The facility staff member making the request will be notified in writing of the outcome of the request.

Additionally:

- All requests will be considered on a case-by-case basis.
- Although income eligibility guidelines do not apply to transplant assistance, financial means may be considered when evaluating request.
- Transplant recipients or living donors, but not both parties, will be considered for an award. Partial awards may be requested for both recipients and donors.
- Dental and/or other medical expenses directly or indirectly related to the transplant are not covered.
- A grant can be awarded for transplant expenses occurred up to 6 months after surgery.
- Insurance premium expenses previously covered by another organization. Example: Insurance premiums previously paid by American Kidney Foundation.

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 7 Transplant Assistance Program	Section 020 Transplant Assistance Process

EFFECTIVE 02-24-2012:

- Transplant grants increased to $1,000.

A written request, addressed to the Director of MoKP, from a transplant facility social worker or facility staff member for Transplant Assistance not to exceed $1,000 should include the following:

- Name and address of kidney recipient and/or name and address of kidney donor
- Who will receive the transplant assistance funds
- The amount requested, not to exceed $1,000 total
- Date of the transplant
- Why the recipient/s is/are in need of the assistance. Be specific, including demographic information and in general the situation, ie, why there is a need.

Following this section are two example letters for the use of the requester.

The transplant facility social worker or staff member making the request will be notified in writing of the outcome of the request.

FACILITY REIMBURSEMENT:
The facility must submit documentation to their MoKP Coordinator indicating the check amount the facility issued to the recipient and/or donor. When the MoKP Coordinator receives this documentation MoKP will reimburse the facility the amount granted including a budget adjustment with the next voucher process.

All requests for reimbursement from MoKP are subject to audit. Refer to Chapter 1 General and Administration Information; Section 1010 Audit/Fiscal Review.

Chapter 7	Section 030
Transplant Assistance Program	**Example Letters**

May 20, 2011 **---- Example Letter 1 ----**

Leanne Peace, Director
Missouri Kidney Program
AP Green Building
201 Business Loop 70W Room 111
Columbia, MO 65211-8180
Re: Transplant Donor Assistance

Dear Mrs. Peace:

I am writing regarding donor financial assistance for XXXXXX, who plans to donate a kidney to his mother, YYYYYY, on 7/2/11. Both donor and recipient are Missouri residents.

XXXXXX is a 19 year-old single male. He lives with his parents and his 13 year-old sister. He is employed part-time at Dominos pizza, working 20-23 hours per week. He is paid $5.50 per hour. He is also going to school full-time at Florissant Valley Community College in Accounting where he is a sophomore. The transplant is planned for early June so XXXXXX can finish school year and recuperate s/p surgery. He will need to be off work for approximately 6 weeks. Unfortunately, since he is working part-time, he is not sure if they will hold his job for him after surgery.

Expenses are as follows:

Telephone	$ 40.00
Car Payment	$136.00
Car Insurance	$150.00
Gasoline	$ 40.00
Loan ($600 total)	$100.00
	$466.00 TOTAL

Please assist XXXXXX with a grant of $500.00 for living expenses while he is off work after transplant surgery. Thank you in advance for your assistance. If you have additional questions, please feel free to contact me at 314-362-5577.

Sincerely,

Example

Chapter 7	Section 030
Transplant Assistance Program	**Example Letters**

July 20, 2011 **---- Example Letter 2 ----**

Leanne Peace, Director
Missouri Kidney Program
AP Green Building
201 Business Loop 70W Room 111
Columbia, MO 65211-8180

RE: Transplant Assistance Grant

Dear Leanne,

I am requesting a grant of $500 to assist XXXXXX with his extreme financial expenses during his recuperation of his cadavaric transplant on 7-11-11.

XXXXXX is a 51 year old male who has had ESRD since Sept. 1985. During his 20+ years of kidney disease, he has had 2 transplants in the early 1980's each failing immediately. Meanwhile he has been on hemodialysis at YYYYYY. Remarkably he has always been able to maintain some employment. In the past 5 years, he has worked part-time as an Advertisement Salesman. This employment is commission sales and very flexible, which was ideal with the hemodialysis schedule and occasionally feeling fatigued. However, this job offers no benefits. He has no sick time, no medical leave, and will have no income during his 2 or 3 months recuperative period. He is very worried about these routine living expenses:

Rent	$250	Car Payment	$340
Utilities	$150	Auto Ins.	$75
Medications	$375	Food/household	$250
Loan/charge	$300	Telephone	$55

This third transplant took him (and us) by surprise. He had been on the waiting list for 10+ years, and really had given up hope. He had made provisions with his car payment and his bank loan for disability payments, however he just discovered they are considering this transplant a pre-existing condition, and will not pay!

XXXXXX is single, with 2 adult children. There are really no financial resources available to him within the family. We have discussed fundraising opportunities, however they don't offer immediate relief, and he isn't too comfortable with this idea.

I have known XXXXXX for many years while a dialysis social worker in Mexico. I have always found him to be a hard working man during his life-long struggle with kidney disease. Please consider this request.

Sincerely,

Example

MoKP Facility Guidelines Manual
University of Missouri-Columbia

Chapter 8	
Forms	**MoKP Network**

The forms needed by the facilities to take advantage of MoKP programs are located on the MoKP secure website. They are available to facility staff with user IDs and passwords with social worker or dietitian access privileges. If you need access to the database to obtain forms, contact your facility's MoKP Coordinator.

Following you will find a copy of all forms available on the MoKP database.

Missouri Kidney Program
University of Missouri Health

Application Worksheet

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

Patient Name: _____ SS# _____

Required Documentation:

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

Other Documentation, if applicable to the requested benefit:

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

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

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

Submitted by: _____

Social worker signature and date

Facility Name: _____

MoKP Fax # 573-882-0167

Missouri Kidney Program
University of Missouri Health

Prescription Order Form

Date: _____

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

From MoKP Facility Name: _____ Phone #:_____

Patient Name (PRINT):_____DOB: ___/___/____

Allergies: _____

Required for Transplant Patients:

Facility Patient Received Transplant: _____

Hospital Discharge Date after Transplant: _____

Diagnosis Codes for Immunos ICD-10:_____

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

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

X_____
Substitution Permitted

X_____
Dispense as Written

X_____
Date

X_____
Date

PRINT Prescriber's name: _____
Medications are to be sent to: (check one): Facility _____ Patient's home_____
(Facility must submit a Kilgore's Prescription Distribution Consent Form if requesting medications be sent to facility.)

Address: _____ (street – no PO boxes)
_____ (city, zip)

Missouri Kidney Program
University of Missouri Health

Income and Asset Information

Complete this page if one of the following is true: (1) you have blind pension MoHealthNet (2) You have MC+ or AFDC – Aid for Dependent Children (3) you do NOT have MoHealthNet coverage (4) you are not financially eligible for MoHealthNet or (5) your spend down is over $1,200/month.

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

1. _____ ____ _____ $_____
Name Age Relationship Total Monthly Income *

$_____ $_____ $_____ $_____
Social Security Blind Pension Employment/Pension Other (list)

2. _____ ____ _____ $_____
Name Age Relationship Total Monthly Income *

$_____ $_____ $_____ $_____
Social Security Blind Pension Employment/Pension Other (list)

3. _____ ____ _____ $_____
Name Age Relationship Total Monthly Income *

$_____ $_____ $_____ $_____
Social Security Blind Pension Employment/Pension Other (list)

4. _____ ____ _____ $_____
Name Age Relationship Total Monthly Income *

$_____ $_____ $_____ $_____
Social Security Blind Pension Employment/Pension Other (list)

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

*Total Monthly Income for each person should equal the total of the four amounts on the line immediately following.

Assets*

Checking Account(s) $_____ CDs/IRAs $_____
Savings Account(s) $_____ Stocks/Bonds/Mutual Funds $_____
Other (money market, credit union accounts, etc.) $_____ Type: _____

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

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

Missouri Kidney Program
University of Missouri Health

MoKP Participant Agreement

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

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

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

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

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

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

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

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

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

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

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

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

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

For Centralized Drug Program/MoKP Contracted Pharmacy applicants only:

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

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

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

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

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

_____ _____

Patient Signature **Date**

_____ _____

Social Security Number **Date of Birth**

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

Missouri Kidney Program
University of Missouri Health

Transplant Update Form

Transplant Facilities:
Complete this form when Missouri Kidney Program participant is transplanted at your facility; and/or a Missouri Kidney Program transplant recipient is tracked by your facility but was transplanted at a facility other than yours.

Name: _____

Birth date: _____

Social Security: _____

Transplant Date: _____

Transplant Facility: _____

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

Prepared by: _____

Telephone: _____

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

Missouri Kidney Program
University of Missouri Health

Mileage and Public Transportation Form

Patient Name: _____ Date _____
PLEASE PRINT

Facility Name: _____

Social Worker: _____

Mode requested (check one)

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

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

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Effective Date: _____ Approved monthly cap: _____

Missouri Kidney Program
University of Missouri Health

Vendor
Transportation Form

Patient Name: _____ Date _____
PLEASE PRINT

Facility Name: _____

Social Worker: _____

Vendor Transportation: must submit two quotes

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

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

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

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

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

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

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

Comments: _____
_____
_____

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

Social Worker Signature: _____

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

Effective Date: _____ Review Date: _____ Approved monthly cap: _____

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: _____

Month/Year of Treatment: _____

Dates of Dialysis Treatments – circle ALL dates of treatment

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

Total number of treatments: _____

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

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

_____

_____

Patient Signature: _____ Date: _____

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

Social Worker Signature: _____ Date: _____

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

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

Missouri Kidney Program
University of Missouri Health

Consent for Medicare Part D Enrollment 2020

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

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

Address: _____

City: _____

Zip Code: _____ County: _____

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

Home Phone Number:_____ Cell Phone Number: _____

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

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

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

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

Signature: _____ **Date:** _____

Guardian or Relationship if signing for patient: _____

MoKP#	**Coordinator:**	**Social Worker:**
Medicare #		
Part A Date:	**Part B Date**	
Current PDP:		
Comments:		

MOHealthNet Application Cover Sheet

Client/applicant name:_____

Dialysis / transplant facility: _____

Social Worker: _____

Social worker phone: _____

Social worker fax: _____

MOKP status:

Client currently on MOKP

MOKP application pending

Completing MOKP application along with MOHealthNet application

Not applying for MOKP, please forward MOHealthNet application to the local county FSD office.

PLEASE ATTACH THIS FORM TO THE MOHEALTHNET APPLICATION WHEN MAILING OR FAXING TO THE MOKP/ STATE FSD WORKER. (Melissa Krapf).

Melissa Krapf
Fax Number: 573-884-5276
Phone Number: 866-665-7373
Address: MoKP FSD Case Worker
201 Business Loop 70 West
AP Green Building Suite 111
Columbia, MO 65201

Revised 10-10-16