

## **Anatomical Gift Public Awareness Category III Grant Application Instructions**

### **Purpose:**

The purpose of Anatomical Gift Public Awareness Fund (AGPAF), Category III grant, is to provide financial assistance for **reimbursement** of *patient costs not available from any other third-party payor*. Payments may be made for the following:

1. Costs of organ transplantation procedure;
2. Costs of post-transplantation drugs or other therapy; and
3. Other transplantation costs including but not limited to food, lodging, and transportation for recipient, living donors, or immediate family member/caretaker.

**Eligibility Requirements:** Eligible applicants shall be transplant recipients or donors, transplant candidates, or a transplant recipient's or transplant candidate's legal representative.

### **Supporting Documentation:**

Funding requests shall include supporting documentation (itemized receipts) provided by a hospital that performs transplants, verifying that the grant applicant requires a transplant and specifying the costs associated with the following:

1. The costs of the organ transplantation procedure;
2. The costs of post-transplantation drugs or other therapy; and
3. Other transplantation costs including but not limited to food, lodging, and transportation.
  - Lodging expenses incurred on 01/01/2012 or after will be reimbursed at \$83 + taxes per night. Lodging expenses for dates prior to 01/01/2012 will be reimbursed at \$75 + taxes per night.
  - Transportation (mileage) is reimbursed at 39¢ per mile.

***NOTE:*** Receipts must be itemized and indicate the name of the establishment, the date and time of service/purchase, and the item(s) purchased. Receipts must be grouped together by category, e.g. parking, lodging, meals & food, misc. and in chronological order. Small receipts must be taped to an 8 ½ x 11 piece of paper. Do not cover any information with tape as it erases the information.

### **Funding Source:**

The AGPAF-Category III consists of funds collected by county treasurers as a contribution from the public when purchasing motor vehicle registrations. The funds are allocated as per Iowa Code Chapter 142C.15.

### **Available Funds**

Funding is ongoing. Grant applications will be received and evaluated by the Iowa Department of Public Health (IDPH) Program Planner as received. Grant applications meeting the requirements will be awarded funding as available and appropriate.

**Payments and Reporting Requirements:**

Payments shall be made on a reimbursement basis on forms provided by IDPH.

Grant applications must be maintained and available for review by IDPH for five (5) years following the grant period.

These reimbursements are considered State Aid and therefore will not generate a form 1099 for taxes. However, applicants should confer with a financial advisor if any questions.

**Grant Application Process:**

To be considered for funding, an original grant application shall be completed and mailed to the following:

Iowa Department of Public Health  
Attn: Sherry Frizell  
Lucas State Office Building-6<sup>th</sup> Fl., 321 East 12<sup>th</sup> Street  
Des Moines, IA 50319-0075

The grant application must have **original** signatures; facsimile applications will not be considered. Appropriate information must be provided in Description of Short-Term Need section and sub-totals and total amount requested indicated. Applications that are incomplete will be returned to the applicant or sponsoring transplant center prior to further consideration.

**Application Format and Content:**

The application must be in the format of that provided. Photocopies or exact computer-generated replicas are permissible.

An original signature **must** be provided at the bottom of page 3 by the applicant and on page 5 by an appropriate hospital official.

**Questions:**

Questions concerning the application should be directed to:

Iowa Department of Public Health  
Attn: Sherry Frizell  
Lucas State Office Building-6<sup>th</sup> Fl., 321 East 12<sup>th</sup> Street  
Des Moines, IA 50319-0075  
Telephone: 515-281-4636, facsimile: 515-281-4535  
E-mail: [sherry.frizell@idph.iowa.gov](mailto:sherry.frizell@idph.iowa.gov)

**For IDPH use only**

Documentation supporting reimbursement of transplantation expenses received and reviewed. Approve reimbursement for the following amount:

\$ \_\_\_\_\_ orgn 5101

\_\_\_\_\_  
Sherry L. Frizell

\_\_\_\_\_  
Date

**APPLICATION**

**STATE of IOWA  
ANATOMICAL GIFT PUBLIC AWARENESS GRANTS  
CATEGORY III – Grant Award Program for Transplant Costs**

This application will be used to determine the patient's eligibility and severity of need for financial grant assistance. This application must be completely filled out by the patient/parent/legal guardian. Applications which are received with sections that have not been fully completed will be returned to the applicant or sponsoring transplant center for completion prior to further consideration.

**PRINT OR TYPE ALL INFORMATION**

Date Completed: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_

Number of dependents: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Patient's Mailing Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Is patient currently employed? Yes  No  If yes, state position: \_\_\_\_\_ and name and address of employer: \_\_\_\_\_

Individual completing this application if not the patient (legal representative, guardian etc.):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**TRANSPLANT PROCEDURE INFORMATION**

Type of transplant: \_\_\_\_\_ Date of transplant: \_\_\_\_\_

Dates of hospital stay/s: \_\_\_\_\_

Date of release to return to home: \_\_\_\_\_

Is the patient a recipient?  or a donor?   
If donor, is the recipient a legal resident of Iowa? Yes  No

**Description of Short-Term Need**

**A. Costs of organ transplantation procedure:**

Description	Cost
_____	\$ _____
_____	\$ _____
_____	\$ _____
Transplant Subtotal	\$ _____

**B. Costs of post-transplantation drugs (prescriptions) or other therapy:**

Description	Cost
_____	\$ _____
_____	\$ _____
_____	\$ _____
Rx Subtotal	\$ _____

**C. List of medications pre-transplantation:**

\_\_\_\_\_  
\_\_\_\_\_

**D. Other transplantation costs including but not limited to food (**itemized receipts required**), lodging, and transportation for recipient, living donors, or an immediate family member/caretaker.**

Description	Cost
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
Other Subtotal	\$ _____

Does the patient receive insurance or other coverage related to these costs? Yes  No

Type of coverage/name of provider \_\_\_\_\_ \$ \_\_\_\_\_  
\_\_\_\_\_ \$ \_\_\_\_\_  
**TOTAL** \$ \_\_\_\_\_

Has coverage been exhausted and grant request is for items not covered? Yes  No

**TOTAL Dollar Amount Requested** \$ \_\_\_\_\_





