The Alabama Kidney Foundation serves kidney patients by providing financial assistance, education, recreational opportunities and support services. The Foundation provides public education to promote organ donation awareness and prevention of kidney disease.

CURRENT CRITICAL NEED

TREATMENT RELATED TRANSPORTATION PROGRAM GUIDELINES

PROGRAM ELIGIBILITY

The Alabama Kidney Foundation Critical Need Treatment Related Transportation Assistance Program is a special one year program designed specifically to meet the critical transportation needs of Alabama's residents who are end stage renal disease patients, as diagnosed by a physician. Patients must apply for assistance through a licensed social worker. The Foundation has no direct contact with the patient or with transportation providers.

- All Medicaid eligible patients should be referred to Alabama Medicaid Net.
- The social service professional should use the Alabama Medicaid Financial Guidelines for Qualified Medicare Beneficiary (QMB) Program Limits (listed below) as a starting point of reference when considering patients for enrollment in this program. Please note that not all QMB eligible patients will be accepted due to limited funding.

1.Person Household Approximately $1,000/month total household income (maximum)
2.Person Household Approximately $1,200/ month total month total household income (maximum)

(Married or single with dependents — must state number and age of dependents.)

- To ensure that the program stays within its budgetary limitations, the program can only accept a limited and predetermined number of patients. All applicants will be thoroughly screened by a voluntary review committee and must meet specific and ranked criteria to qualify.

APPLICATION PROCESS

All applications must include the following:

I. Application Form
All information requested is essential for application to the program.

2. Medicaid Non Emergency Transportation Program Form
Must be completed including signatures where noted.
3. Sources of Income and Expense Form Include verification
for all income.
4. Separate Verification of Income from Social Security
You may request that it be sent directly to the patient, or you may use the enclosed "consent for release of information" form. The form should be completed and sent to Social Security for verification of the patient's income. When the verification is returned to you, it is to be submitted with the other three forms listed here. (Other documentation, i.e. current tax return, paycheck stub, W2 from patient/spouse will suffice for income verification.)

All incomplete applications and/or applications submitted on outdated forms will be returned.

REIMBURSEMENT POLICY

- Minimum Disbursement: There is no minimum disbursement in the Critical Need Program.
- Maximum Disbursement: Patients enrolled in the Critical Need Program with reported treatment related travel for the month addressed will receive no more than $175, regardless of trips, distance or rate charged for service.
- Van Service/Taxi: The program will disperse up to S13.00 in assistance for one round trip traveled in a licensed/insured van service and/or taxi.
- Hired Driver: The Critical Need Transportation Program will base assistance issued for a treatment related hired-driver service on the following schedule.

A.	01-15 miles one-way	--	S2.50/trip maximum
B.	16-35 miles one-way	--	$4.50/trip maximum
c.	36-?? miles one-way	--	S6.50/trip maximum

- Personal Vehicle: The Critical Need Transportation Program will reimburse $0.20 per mile up to $13.00 for one round trip traveled in a personal vehicle.

ALABAMA KIDNEY FOUNDATION, INC.

CRITICAL NEED TRANSPORTATION PROGRAM

ENROLLMENT APPLICATION

Date of Application:

_____

Patient's Social Security Number:_____ - ____ - _____

Patient Name:

_____

First Name Middle Name Last Name

Patient Address:

_____

Street

_____

City State Zip County

Date of Birth:_____/_____/_____

Home Phone:Sex: [I Male [J Female

_____

Race: (African American) ____(Cauc) _____(Hisp) _____(Asian)___(Amer. Ind.) _____(Other)____

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Dependents: [ ] No [ ] Yes If "Yes" _____ give age of each_____

Number

Dialysis Unit Serving Patient: _____ one Way Mileage to Dialysis Unit: _____

Mode of Travel to and from Unit: [ ] Van [[ ] Taxi [ ] Hired Driver [ ] Personal Vehicle

Dialysis Unit Address:

_____

Street City State Zip

Dialysis Unit Telephone Number: _____FAX Number:_____

Social Worker (Print Name)_____

Medicaid Number (QMB Patients Only): _____

ALL APPLICATIONS SHOULD INCLUDE THE FOLLOWING:

Please check.

[ ] Enrollment Application (All information requested is essential for enrollment in the program.)

[ ] Sources of Income and Expenses (Include verification for all income.)
Social Worker should assist patient to ensure the form is as complete and accurate as possible.

[ ] Verification of Income from Social Security. (A Statement of Claimant Form may be sent to Social Security for verification of income. Submit response with the other three forms listed here. Other documentation — current tax return, paycheck stub, W2 form from patient/ spouse will suffice for income verification.)

[ ] Medicaid Non-Emergency Transportation Program

PLEASE FILL OUT ALL FORMS COMPLETELY. Incomplete applications will be returned for completion.

CRITICAL NEED TREATMENT RELATED TRANSPORTATION ASSISTANCE PROGRAM

APPLICATION FORM

Date of Application:_____

Patient's Social Security Number:

_____ - ____ - _____Patient's County of

Resident_____

One Way Mileage to Dialysis Unit: _____

Mode of Travel [ ] Van [ ] Taxi [ ] Hired Driver [ ]]Personal Vehicle

---

Is this patient QMB eligible? [ ] Yes [ ] No

Is this patient wheelchair bound? [ ] Yes [ ] No

What effort has taken place to secure other means of transportation for this patient? Please be specific.

_____

_____

_____

Does this patient live in a rural area (defined as an area that lacks adequate public services for disabled persons)? [ ] Yes [ ] No

Is public transportation an option for the patient? Please explain.

[ ] Yes [ ] No

_____

_____

_____

Are family members/friends available to help this patient with travel? Please explain.

[ ] Yes [ ] No

_____

_____

Is this a new start patient who is not yet receiving benefits? Please explain.

[ ] Yes [ ] No

_____

_____

_____

What is patient's dialysis schedule?

_____

Does this schedule interfere with options for transportation? Please explain.

_____

Has the dialysis clinic tried to accommodate this patient's transportation needs by changing the dialysis schedule? Please explain.

_____

SOURCES OF INCOME AND EXPENSES FORM

Date of application: _____ Patient's Social Security Number_____ - _____ - _____MONTHLY INCOME

Gross Household [ ] Currently Employed $ _____

$ _____

$ _____

Salary [ ] Spouse Employed
[ ] Other Employed Adult Living in Home
[ ] Not Currently Employed
[ ] Never Worked Outside Home

****

Social Security [ ] Yes $ _____
Or SSI [ ] Pending
[ ] Not Eligible

Comments:_____

_____

****

Social Security [ ] Yes $ _____
Disability [ ] Pending
[ ] Not Eligible

Comments:

_____

_____

****

IRA [ ] Yes $ _____
Pension [ ] Yes $ _____
Retirement [ ] Yes $ _____

Comments:_____

_____

****

Other Income/Financial Resources:

(EXAMPLES INCLUDE: Child Support, Alimony, Company Disability, Medicaid NET, Food Stamps, Welfare, Aid to Dependents, Veteran's Benefits, Dividend and Interest Income, Rental Income, etc.)

Please Specify and Explain _____ $ _____
_____ $ _____
_____ $ _____

TOTAL MONTHLY INCOME: $ _____

****

ASSETS

Checking Account Value $ _____

Bank Name:

$ _____
Home $ _____
$ _____

Car
Other Assets
Please Specify and Explain _____ $ _____

TOTAL ASSETS $ _____

MONTHLY EXPENSES

[ ] Rent[ ] Mortgage $_____

Utilities

Electricity $ _____
Gas $ _____
Water $ _____
Telephone $ _____
Cable $ _____

Food Household Expenses $ _____

Clothinq $_____

Insurance

Health $ _____
Life $ _____
Automobile $ _____
Burial $ _____
Homeowner's/Renter's $ _____
Other $ _____

Automobile

Payment Gasoline $ _____
Maintenance $ _____
$ _____

Monthly Travel Costs of Dialysis $ _____

Medication

Monthly Cost (including Co-Pay) $_____

Other Family Member's Medication Costs $ _____

Miscellaneous

Loan Payments Charge Accounts $ _____
Medical Supplies Cell Phone/Pager $ _____
Child Support $ _____
Alimony $ _____
Child Care $ _____
Education (Student Only) $ _____
$ _____
$ _____
$ _____

TOTAL MONTHLY EXPENSES $ _____

[f monthly expenses exceed monthly income by $200 or more, please explain:

_____

_____

_____

MEDICAID NON-EMERGENCY TRANSPORTATION PROGRAM Statement of Ineligibility

l, the referring social services professional, have verified that the indicated patient applicant to the Alabama Kidney foundation Treatment-Related Transportation Assistance Program is NOT eligible for similar assistance through the Alabama Medicaid Non-Emergency Transportation (NET) Assistance Program. The Alabama Medicaid NET Assistance Program regional coordinator listed below was my reference for this verification.

_____

Patient Applicant (Please print full name)

_____

Dialysis Facility

_____

Social Service Professional — Printed Name

_____

Social Service Professional — Signature

_____

Medicaid NET Reference (Print name and telephone number)