AMERICAN TRANSPLANT FOUNDATION

PATIENT ASSISTANCE PROGRAM
Living Organ Donor Application Guide

*Please thoroughly review instructions and guidelines prior to filling out this application for your Social Worker/Transplant Coordinator. *

OVERVIEW

Living donor financial assistance grants are meant to cover lost wages during the donation surgery recovery period. These grants can cover living expenses for which the grantee receives a monthly bill, such as rent/mortgage, utilities, car payments etc.

GENERAL GUIDELINES

- While patients may fill out this printed document, the application ***must*** be submitted by a social worker or living donor coordinator online. No paper copies will be accepted.
- Applicants ***must*** be employed at the time of the application/surgery. We require a signed form from your employer stating available paid time off and/or short term disability
- Documentation stating amount of paid time off and/or short-term disability is required to complete the application. If you are self-employed and are ineligible for paid time off, please discuss your potential eligibility for state short-term disability with your social worker.
- Staff at the American Transplant Foundation will communicate with the social worker and vendor directly. Patients are strongly discouraged from contacting the Foundation about the status of their application and should contact their social worker with questions.
- Applications are reviewed on a case-by-case basis. Eligibility for financial assistance is based on the sole discretion of the American Transplant Foundation and is subject to the availability of funds available.
- Applications may be approved for a different amount than requested at the discretion of the voting committee.
- All disbursements are made directly to the vendor, never to the patient.
- Grants will only be sent to vendors with a billable address, never to general items such as groceries or transportation costs.
- Patients are **ineligible for grants** if they will be receiving 100% paid time off through their employer, if their savings covers/exceeds their lost wages, or if their paid time of combined with savings will cover their lost wages.

This document is a grant application guide and <u>will not be accepted</u> in place of the official online application. Do not submit this document via fax or email.

APPLICATION TEMPLATE

1. PATIENT INFORMATION

Name (first/last):

Phone Number (primary/secondary):

Email:

Complete Mailing Address:

2. RESEARCH QUESTIONS – The following questions are required but the answers will not affect eligibility to receive a Patient Assistance grant. Answers will help our foundation to demonstrate the need for funding for this program and may help us tailor assistance to transplant patients in the future.

Gender:

Date of Birth:

Primary Language:

Race/Ethnicity:

Please mark all that are true. A financial grant from the American Transplant Foundation would:

- ☐ Make it possible to donate an organ
- ☐ Help with stress and reduce worry
- ☐ Help avoid debt/falling behind on bills during recovery
- ☐ Help avoid returning to work too soon post-transplant (before fully recovered)

If awarded this grant, would you be willing to provide a written or video testimonial and/or a photo explaining the impact that the grant had on your transplant journey? This would be posted on the American Transplant Foundation website.

YES NO (circle one)

3. TRANSPLANT INFORMATION

Type of transplant (i.e., kidney, liver, lobe of lung):

Directed/non-directed living donor?
(circle one – if donating to a specific individual, select directed. If donating to an unidentified stranger, select non-directed.)

Paired exchange/donation chain?
(circle one if applicable)

Are you donating through the National Kidney Registry program? (Kidney donors only):
YES NO (circle one)

Are you participating in a living donation chain? YES NO (circle one)

Relationship to organ recipient *(ex. recipient is my aunt, husband, son, friend* etc):
(Please note, if your recipient is a spouse, you will need to fill out financial information for them as well)

Surgery Date:
(Surgery date must be confirmed for your application to be considered. If you are participating in a donation chain, please put an estimated date for surgery and have your social worker contact our staff immediately once surgery is scheduled)

4. EMPLOYMENT INFORMATION:

Current employer:

Job title:

Full time or part time employee? (circle one)

Second employer (if applicable):

Job title:

Will you be receiving any short-term disability? YES NO (circle one)

If YES, please answer the following questions:

- **How long will you receive short term disability?** (specify number of weeks):
- **What percent of your standard pay will you receive through short term disability?** (i.e. 20%, 10%, etc.):

Will you be receiving any paid time off? YES NO *(circle one)*

If YES, please answer the following questions:

- **How much paid time off will you receive?** *(please specify number in weeks):*
- **What percentage of your standard pay will you receive in paid time off?** (i.e. 20%, 10%, etc.):

If you are donating and organ to your spouse, please answer the following questions:

- **Is your spouse employed?** YES NO *(circle one)*
- **Is your spouse receiving any time off?** YES NO *(circle one)*
- **If YES, please answer the following questions**
    - **How much paid time off will you receive?** *(please specify number in weeks):*
    - **What percentage of your standard pay will you receive in paid time off?** (i.e., 20%, 10%, etc.):

What is your total estimated lost wages during time off during recovery (after taxes)**?** For example, if you will be out 2 weeks, won't receive time off and your standard monthly pay is $4,000, please put $2,000 *(must be reflected in income information below):*

Total Amount Requested *(please see website for current max grant amount):*

5. FINANCIAL INFORMATION

Are you the head of the household? YES NO *(circle one)*

Do you have a partner/spouse in the household? YES NO *(circle one)*

Number of legal dependents *(claimed on taxes)***:**

- **Ages of legal dependents** (claimed on taxes)**:**

Amount in savings account: $

Monthly household wages contributed by patient *(after taxes, standard monthly amount)**: $***

Monthly household wages contributed by others *(by all members that contribute to the household)**: $***

Social Security Income: $

Disability Income: $

Monthly Mortgage/Rent: $

Monthly Insurance and Medical Costs: $

Other monthly household living expenses *(this includes groceries, transportation; phone, utilities, car insurance, etc.)***: $**

6. PATIENT'S INSURANCE INFORMATION

Medicare? YES NO *(circle one)*

Medicaid? YES NO *(circle one)*

Private Insurance? YES NO *(circle one)*

- **Name of Insurance Company:**

7. VENDOR INFORMATION (Up to three vendors only):

Vendor 1 Name:

Vendor billing address (Please verify that this is the correct address where a third-party check will be sent. If you submit incorrect addresses, names, or client ID numbers in this section, you may be at risk for not receiving funding)**:**

Client /Account ID:

Contact Phone:

Amount requested from vendor:

Total amount owed to vendor:

What type of expenses is this?

Vendor 2 Name:

Vendor billing address (Please verify that this is the correct address where a third-party check will be sent. If you submit incorrect addresses, names, or client ID numbers in this section, you may be at risk for not receiving funding)**:**

Client /Account ID:

Contact Phone:

Amount requested from vendor:

Total amount owed to vendor:

What type of expenses is this?

Vendor 3 Name:

Vendor billing address (Please verify that this is the correct address where a third-party check will be sent. If you submit incorrect addresses, names, or client ID numbers in this section, you may be at risk for not receiving funding):

Client /Account ID:

Contact Phone:

Amount requested from vendor:

Total amount owed to vendor:

What type of expenses is this?

Thank you for your interest in the Patient Assistance Program Grant and filling out this application for your social worker or living donor coordinator.

We will communicate with your social worker regarding the status of your grant request once they have submitted it on your behalf online. We wish you the best of luck with your transplant surgery and hope you have a quick recovery!

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