AMERICAN TRANSPLANT FOUNDATION

PATIENT ASSISTANCE PROGRAM
Organ Transplant Recipient Application Guide

Please thoroughly review instructions and guidelines prior to filling out this application for your social worker/transplant coordintor.

OVERVIEW

Transplant recipient financial assistance is a one-time grant that is meant to cover an emergency or gap period in insurance coverage or medication access. These grants can cover insurance premiums, transplant-related copays, and direct pharmacy costs. For long-term funding solutions, a social worker must be contacted.

GENERAL GUIDELINES

- While patients may fill out this printed document, the application ***must*** be submitted by a social worker or transplant coordinator online. No paper copies will be considered.
- 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 his or her application and should reach out to their Social Worker or Transplant Coordinator 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.
- Not all insurance companies and pharmacies will accept a third-party payment. Please verify this information with the vendors prior to submitting the application.

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:

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)

On a scale of 1 to 5, how influential will this financial assistance be in order for the patient to maintain their transplant?

- ☐ 1. Will have access to meds regardless of this grant
- ☐ 2. Will help ease the situation
- ☐ 3. Will be very helpful
- ☐ 4. Will be extremely necessary
- ☐ 5. Essential, won't have access to meds in the next 30 days without this grant

3. TRANSPLANT INFORMATION

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

Surgery Date:

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

4. EMPLOYMENT HISTORY

Are you currently employed? YES NO (circle one)

Last or current employer:

Job Title:

Last date of employment:

Will you receive any paid time off during recovery? (if pre-surgery)**:**

YES NO (circle one)

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?

*The following question is required but will have *no impact* on the consideration of your grant application status*

What would financial assistance mean to you?

Thank you for your interest in the Patient Assistance Program Grant and filling out this application for your social worker or transplant 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 a quick recovery!

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AmericanTransplantFoundation.org

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