

# TRANSPLANT FUNDRAISING APPLICATION

Providing this information will not adversely affect any consideration you may receive for GTF services



## CLIENT INFORMATION

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apartment/Unit# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Male  Female   
Marital Status \_\_\_\_\_ Spouse's Name (if applicable) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Total # of People Living in Household \_\_\_\_\_ Children in Household \_\_\_\_\_ Adults in Household \_\_\_\_\_

Date of Transplant (if applicable) \_\_\_\_\_ Organ \_\_\_\_\_ Transplant Center \_\_\_\_\_

## DEMOGRAPHIC INFORMATION

**Race** (optional - please check)  Hispanic  African American  Black  White, Non-Hispanic  
 Asian-American  Asian-Pacific Islander  Native American  Other

**Level of Education** (optional -please check)  GED  Attended High School (# of years \_\_\_\_  High School Graduate  
 Technical Certificate/Diploma  Currently Enrolled in College  Attended College (# of years \_\_\_\_)  
 Associates Degree  Bachelors Degree  Masters Degree  MD/PhD  Other \_\_\_\_\_

**Current Source of Income** (please check all that apply)  Full-Time Employment  with benefits  Working Spouse  
 Part-Time Employment  with benefits  Parents Income  Retirement Pension  
 Social Security Retirement  Social Security Disability (SSDI)  Supplemental Security Income (SSI)

**Work Status** (please check)  Currently Employed; Employer Name \_\_\_\_\_  
 Medically Disabled \_\_\_\_\_  Retired  Unemployed \_\_\_\_\_  
Date Date

**Current Source of Healthcare Coverage** (please check all that apply)  
 Insurance (please circle: BCBS; United Healthcare; Humana; Kaiser; Atena; Other \_\_\_\_  Spouse's Insurance  
 Medicare  Medicaid  QMB Medicaid  Spend-down Medicaid  COBRA

**Check all that apply to you:**  Recipient  Candidate  Living Donor  JumpStart Client  
 Trends In Transplant (TNT) Conference Attendee  Fundraising Workshop Attendee  
 Mentor with The Mentor Project  GTF Volunteer/ Board Member/ Committee Member

**How did you hear about GTF services?**  GTF Website/ IMPRINT Magazine/ Brochure  GTF Staff, Name \_\_\_\_\_  
 GTF Volunteer, Name \_\_\_\_\_  Transplant Center Staff, Name \_\_\_\_\_

Name \_\_\_\_\_

PLEASE ANSWER **ALL** QUESTIONS FOR THE REVIEW COMMITTEE

**PART ONE - TRANSPLANT CENTER INFORMATION**

|                                |   |
|--------------------------------|---|
| <b>Transplant Center</b>       | <b>Organ Needed</b>   |
| <b>Financial Coordinator</b>   |   |
| <b>Transplant Coordinator</b>  |   |
| <b>Social Worker</b>           |   |
| <b>I am:</b>                   | <input type="checkbox"/> Currently being evaluated for transplant <input type="checkbox"/> Listed for transplant <input type="checkbox"/> Transplanted (Date) _____ |
| <b>I am raising funds for:</b> | <input type="checkbox"/> Medications <input type="checkbox"/> Donor/Organ Procurement Costs <input type="checkbox"/> Other Transplant-Related Costs                 |

**PART TWO - INSURANCE INFORMATION**

**Type of Coverage:** Medicare  A  B  D       Medicare Advantage       Medicare Supplement \_\_\_\_\_  
 Katie Beckett       Medicaid       Medicaid Spend-Down       QMB Medicaid

**Insurance:** Primary \_\_\_\_\_ Secondary \_\_\_\_\_

**How do you have this coverage?**       ESRD       My Employment       Spouse's Employment  
 COBRA       Retirement       Disabled       Other \_\_\_\_\_

**What does your insurance cover for transplant?** \_\_\_\_\_

**What will NOT be covered with your current insurance plan?** \_\_\_\_\_

**What other non-medical expenses are anticipated? Please explain:** \_\_\_\_\_

**Will there be ANY changes in your insurance coverage after your transplant? Please explain:** \_\_\_\_\_

Name \_\_\_\_\_

PLEASE ANSWER **ALL** QUESTIONS FOR THE REVIEW COMMITTEE

**PART THREE - FINANCIAL INFORMATION**

**DO NOT LEAVE ANY FIELD BLANK**

**ASSETS:**

CHECKING \$ \_\_\_\_\_  
SAVINGS \$ \_\_\_\_\_  
STOCKS & BONDS \$ \_\_\_\_\_  
RETIREMENT ACCOUNTS \$ \_\_\_\_\_

**AUTOMOBILE(S):**

YEAR \_\_\_\_\_ YEAR \_\_\_\_\_  
MAKE \_\_\_\_\_ MAKE \_\_\_\_\_

**Household:** All people living in your home (includes all children or adults), non-related household members, parents, grandchildren, siblings, renters, etc.

**Income:** Total amount for wages or salary income, self-employment income, interests, dividends and rental income, Social Security Retirement and Social Security Disability Income, Supplemental Security Income, child support, public assistance, TANF, food stamps, family's financial help, income from working children, parents, siblings, etc. who reside in your household.

**Expenses:** General household expenses per month - rent/mortgage, food, average utilities, phone charges - basic phone, cell phone, credit card payments - monthly amount, not total balances owed.

**MONTHLY HOUSEHOLD NET INCOME**

(please read above description)

WAGES (net) \$ \_\_\_\_\_  
SPOUSE'S INCOME \$ \_\_\_\_\_  
FAMILY MEMBER'S INCOME \$ \_\_\_\_\_  
SOCIAL SECURITY (SSDI, SSI) \$ \_\_\_\_\_  
ADDITIONAL DISABILITY \$ \_\_\_\_\_  
PENSION \$ \_\_\_\_\_  
RETIREMENT INCOME \$ \_\_\_\_\_  
VETERAN'S PENSION \$ \_\_\_\_\_  
TANF \$ \_\_\_\_\_  
FOOD STAMPS \$ \_\_\_\_\_  
RENTAL \$ \_\_\_\_\_  
DIVIDENDS \_\_\_\_\_  
OTHER \$ \_\_\_\_\_  
\$ \_\_\_\_\_  
**TOTAL MONTHLY INCOME** \$ \_\_\_\_\_

**MONTHLY HOUSEHOLD EXPENSES**

(please read above description)

RENT\*  MORTGAGE\*  \$ \_\_\_\_\_  
FOOD \$ \_\_\_\_\_  
UTILITIES \_\_\_\_\_  
TELEPHONE \$ \_\_\_\_\_  
GAS & ELECTRICITY \$ \_\_\_\_\_  
CELL PHONE \$ \_\_\_\_\_  
WATER \$ \_\_\_\_\_  
TRANSPORTATION \_\_\_\_\_  
PUBLIC TRANSPORTATION \$ \_\_\_\_\_  
AUTO PAYMENT \$ \_\_\_\_\_  
GASOLINE \$ \_\_\_\_\_  
MEDICAL EXPENSES \_\_\_\_\_  
DOCTORS FEES \$ \_\_\_\_\_  
HOSPITAL PAYMENTS \$ \_\_\_\_\_  
MEDICATIONS \$ \_\_\_\_\_  
DENTAL \$ \_\_\_\_\_  
INSURANCE \_\_\_\_\_  
MEDICAL \$ \_\_\_\_\_  
LIFE \$ \_\_\_\_\_  
AUTO \$ \_\_\_\_\_  
CHARGE ACCOUNTS \_\_\_\_\_  
BANK CARDS (monthly payment) \$ \_\_\_\_\_  
OTHER \_\_\_\_\_ \$ \_\_\_\_\_  
OTHER \_\_\_\_\_ \$ \_\_\_\_\_  
**TOTAL MONTHLY EXPENSES\*\*** \$ \_\_\_\_\_

***I authorize information released between GTF and my transplant center or other related parties to verify information related to this request. I agree to be added to GTF's database for future mailings.***

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\* If you are not paying rent or a mortgage, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\* If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

PLEASE ANSWER **ALL** QUESTIONS FOR THE REVIEW COMMITTEE

**PART FOUR - FUNDRAISING**

Why do you need to fundraise? \_\_\_\_\_

Has your transplant center required you to prepare a financial plan for your transplant?

What have you done to plan for your transplant? \_\_\_\_\_

|  |                  |
|--|------------------|
| Have you already raised funds?               | If so, how much? |
| Have you attended GTF's Fundraising Workshop | If so, when?     |

GTF conducts Fundraising Workshops throughout the year. Please call 1-866-428-9411 or visit our website ([www.gatransplant.org](http://www.gatransplant.org)) for dates.

**PART FIVE - TRANSPLANT FUNDRAISING PROGRAM ACCOUNT**

Please choose **ONE** type of account. You must have a fundraising account held at GTF to be eligible for this program.

- MATCHED - this account is matched by GTF**
- Funds are matched up to a maximum of \$10,000, if raised within the first year.
  - Application is required before transplant
  - Funds are limited to \$1,000 for non-medication costs
  - This account is subject to a 3% administrative fee, which is charged to the patient's GTF account

**OR**

- UNMATCHED ACCOUNT - this account is NOT matched**
- Eligible to apply post-transplant
  - Funds are available for reasonable pre and post transplant expenses
  - Expanded limits on non-medication transplant related costs

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**DIRECT PHARMACY BILLING (Optional)** I would like to use the direct billing process for my post-transplant medication. Medicine is supplied by Bioscrip, a pharmacy that GTF has partnered with. This process will allow Bioscrip to bill my insurance, Medicare or Medicaid for the cost of my post-transplant medication. The balance or co-pay will then be directly debited from my GTF fundraising account. This process will allow me to have my fundraising account directly billed so that I do not have to pay upfront for my medication. I understand that if my account is a matched one, GTF will pay the match to Bioscrip Pharmacy from the GTF account. It is my responsibility to notify my transplant center that I have chosen this option at the time of transplant. It is my responsibility to monitor this billing process by contacting

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**MANDATORY:** In addition to yourself, please identify who is authorizes to handle your financial affairs. This person can be a spouse, relative, or a friend, but will be the only person GTF will discuss your fundraising account with.

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**TO APPLY TO THE TRANSPLANT FUNDRAISING PROGRAM, YOU MUST PROVIDE THE FOLLOWING DOCUMENTS:**

**• Proof of Georgia residency during the last six (6) months prior to the application date**

Proof of residency can be a copy of your driver's license (or non-driver's ID) with the EXAM date of six months old or older than the application date (the exam date is located next to your date of birth, a **six-month old** utility bill, a **six-month old** bank statement, a letter from your dialysis or transplant center stating that you have been a patient there for six months. This document should include your name, current address and a date six months prior to the date you are completing the application.

**• Proof of current income**

Proof can be in the form of your most recent **Federal** Income Tax return, most recent pay check stub or a Social Security Income statement or bank statement showing monthly SS check deposit.

**• Proof of health insurance**

A front and back copy of your Medicare, Medicaid, or private insurance card. If you do not have health insurance, please note that on the application.

***PLEASE NOTE THAT YOUR APPLICATION WILL NOT BE REVIEWED IF YOU ARE MISSING ANY OF THE ABOVE REQUIRED DOCUMENTS***

**IF APPLYING FOR THE MATCHED program**, please sign your initials next to **each** statement to indicate that you understand the following:

\_\_\_\_\_ I understand that if my application for a MATCHED account is approved, I will be reimbursed and matched AFTER I receive my transplant, once I begin to buy/pay for my prescription post-transplant medications and/or approved post-transplant related expenses.

\_\_\_\_\_ I understand that if my application for a MATCHED account is approved, my account is subject to a 3% administrative fee that will be debited from my GTF account.

\_\_\_\_\_ I understand that if my application for a MATCHED account is approved, I will be reimbursed and matched for the following:

- Prescription drugs necessitated by my transplant.
- A total of \$1000 for any of the following categories combined:
  - Medical bills and co-pays related to my transplant, and/or
  - Travel, lodging and food expenses during my transplant for one (1) caregiver and/or
  - Travel, lodging and food expenses for my follow-up medical care for up to six (6) months post-transplant.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

If assistance is needed for completion of the application or to answer any questions, please contact the Georgia Transplant Foundation (TFP@gatransplant.org, 1-866-428-9411 or 678-514-1170).

**Please mail your completed application and supporting documents to:**

Georgia Transplant Foundation  
Attn: TFP  
500 Sugar Mill Road, Suite 170-A  
Atlanta, GA 30350

Toll Free: 1-866-428-9411

Phone: 770-457-3796

Fax: 770-457-7916

Web: www.gatransplant.org