



Georgia Transplant Foundation

Enriching Lives Everyday

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

CLIENT INFORMATION:

 First Name Middle Last Name

 Mailing Address Apt/ Suite Number

 City State Zip Code County

 Home Phone Cell Phone E-mail Address

 Male Female Marital Status Spouse's Name

 Date of Birth Age Number of adults in your household Number of children in your household

 Date of Transplant (if applicable) Organ Transplant Center

CHILD'S INFORMATION (ONLY if your child is the applicant):

 Name Date of Birth

 Social Security Number Transplant Center

 Date of Transplant (if applicable) Organ

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 (number of years _____),
 _____ High School Graduate, _____ Technical Certificate / Diploma, College (number of years _____),
 _____ Associates, _____ Bachelors, _____ Masters, _____ PhD

Current Source of Income: (Please check all that apply) _____ Full time employment _____ with benefits
 _____ Part-time employment _____ with benefits, _____ Parents Income _____ Retirement pension, _____ Working spouse, _____
 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 _____ Spouse's Insurance _____ Parents Insurance
 _____ Medicare _____ Medicaid _____ QMB Medicaid _____ Spend-down Medicaid _____ COBRA

Check all that apply to you: Recipient Candidate Living donor JumpStart Client Wellness Conference Attendee
 Workshop attendee Mentor with Mentor Project GTF Volunteer/Board Member/Committee Member

How did you hear about GTF Services? GTF Website/Newsletter/Brochure GTF Staff, Name _____
 GTF Volunteer, Name _____ Transplant Center Staff, Name _____

Please read this page very carefully. It is the patient's and/or the caregiver's responsibility to understand the guidelines of the Transplant Fundraising Program.

Holly Vanager-Crummell from Georgia Transplant Foundation (GTF) is available to answer questions regarding this program and can be reached at TFP@gatransplant.org or 678-514-1170.

1. The Transplant Fundraising Program is available to assist transplant candidates and recipients in financially preparing for the ongoing costs associated with transplantation, primarily medication costs.
2. If a patient has a *matched account*, money that is deposited in his/her GTF account is specifically designated for post-transplant related expenses. Post-transplant related expenses are defined as those reasonable expenses that are caused by the transplant after the transplant has occurred. *This account is subject to a 3% administrative fee, which will be deducted from the patient's GTF account.*
3. If the patient has a *matched account*, the patient is reimbursed and matched *after* the transplant once he/she begins to buy/pay for the prescription post-transplant medications and/or approved post-transplant related expenses.
4. If the patient has a *matched account*, there are two methods for reimbursement and match for medication costs.
 - a. **Direct bill by Bioscrip Pharmacy to the patient's GTF account**
So that the patient doesn't have to pay up front and wait for reimbursement, GTF has a partnership with Bioscrip Pharmacy to supply the post-transplant medications, bill the insurance or Medicare/Medicaid and then bill the balance to the patient's GTF account.
 - b. **The patient pays up front and receives reimbursement and match monthly from GTF**
The patient pays for the medications and/or medication co-pays *first* and submits receipts for reimbursement (from the patient's GTF account) and match (from GTF's account).
5. If the patient has a *matched account*, there is one method for reimbursement for other post-transplant related expenses that are not prescription medication:
 - a. **The patient pays up front and receives reimbursement and match monthly from GTF**
The patient pays for the allowable transplant-related expenses first and submits receipts for reimbursement (from the patient's GTF account) and match (from GTF's account).
6. The following are considered reasonable *post-transplant* related expenses for which the funds may be used as outlined in the Transplant Fundraising Program guidelines:
 - Prescription drugs necessitated by the transplant for the patient.
 - Medical bills and co-pays related to the transplant for the patient, subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses during the patient's transplant for one (1) caregiver, subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses for the client's follow-up medical examinations for up to six (6) months post-transplant, subject to \$1,000.00 maximum if in the matched program.
- ★ 7. GTF can only reimburse the following from a patient's account:
 - Prescription drugs necessitated by the transplant for the patient.
 - Medical bills and co-pays related to the transplant for the patient, subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses during the patient's transplant for one (1) caregiver, subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses for the client's follow-up medical examinations for up to six (6) months post-transplant, subject to \$1,000.00 maximum if in the matched program.

Transplant Fundraising Program

A P P L I C A T I O N

Name _____

Social Security Number _____

PLEASE ANSWER ALL QUESTIONS FOR THE REVIEW COMMITTEE

TRANSPLANT CENTER INFORMATION – PART ONE

Transplant Center _____

Organ Needed _____

Financial Coordinator _____

Transplant Coordinator _____

Social Worker _____

I am: Currently being evaluated for transplant Listed for transplant Transplanted _____
Date

I am raising funds for: Medications Donor/Organ Procurement Costs Other transplant-related costs

INSURANCE INFORMATION – PART TWO

Type of Coverage: Medicare A B D Medicare Supplement _____

Katie Beckett Medicaid Medicaid Spend-down QMB Medicaid

Insurance: Primary _____ Secondary _____

How do you have this coverage?

ESRD My Employment Spouse Employment Cobra Retirement Disabled Other

What does your insurance cover for transplant? _____

What with your current insurance plan will NOT be covered? _____

What other non medical expenses are anticipated? Please explain: _____

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

Name _____

FINANCIAL INFORMATION – PART THREE

DO NOT LEAVE ANY FIELD BLANK

ASSETS:

ACCOUNTS:

CHECKING \$ _____

SAVINGS \$ _____

STOCKS & BONDS \$ _____

AUTOMOBILE:

YEAR _____ YEAR _____

MAKE _____ MAKE _____

Household: All people living in your home (includes all children, adult or minor), non-related household members, parents, grandchildren, siblings, renters, etc.
Income: Total amount for wages or salary income, self-employment income, interest, 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) \$ _____
SOC. SEC. (SSDI, SSI) \$ _____
ADDITIONAL DISABILITY \$ _____
PENSION \$ _____
SPOUSE'S INCOME \$ _____
FAMILY MEMBER'S INCOME \$ _____
TANF \$ _____
VETERAN'S PENSION \$ _____
RENTAL INCOME \$ _____
RETIREMENT INCOME \$ _____
DIVIDENDS \$ _____
OTHER (SPECIFY) \$ _____

TOTAL MONTHLY INCOME \$ _____

MONTHLY HOUSEHOLD EXPENSES (please read above description)

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

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

APPLICANT'S SIGNATURE _____ DATE _____

*If you are not paying rent or 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

FUNDRAISING – PART FOUR

Why do you need to fundraise? _____

Has your transplant center required you to prepare a financial plan for your transplant? Yes No

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 Training Seminars throughout the year. Please call 1-866-428-9411 or visit our website (www.gatransplant.org) for the dates.

TRANSPLANT FUNDRAISING PROGRAM ACCOUNT – PART FIVE

Please choose only one type of GTF account. You must have a fundraising account held at GTF to be eligible for the program.

- Transplant Savings Account – this account is NOT matched**
 - ✓ Eligible to apply post-transplant
 - ✓ Funds available for reasonable pre- and post-transplant related expenses
 - ✓ Expanded limits on non medication transplant related costs

- Access to Care Account – matched account**
 - ✓ Funds matched up to a maximum of \$10,000 if eligible
 - ✓ Application 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.

(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 fundraising account. This process will allow me to have my fundraising account directly billed so that I do not have to pay up front for my medication. I further 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 the transplant center that I have chosen this option at the time of transplant.

MANDATORY: Please identify who is authorized to handle your financial affairs in addition to yourself. This person can be a spouse, relative or friend.

Name: _____

Address: _____ City _____ State _____ Zip code _____

Phone Number: (Home) _____ (Mobile) _____ (Work) _____

Relationship to client? _____

TO APPLY TO THE TRANSPLANT FUNDRAISING PROGRAM PLEASE PROVIDE THE FOLLOWING:

If applying for a Transplant Savings Account, please provide:

- **Proof of residency -**
Proof of residency can be a utility bill, a bank statement, a letter from your dialysis or transplant center stating that you are a patient or a copy of your driver's license (or non-driver's ID).
- **Proof of current income -**
Proof can be in the form of your most recent State Income Tax return, most recent check stub or a Social Security Income statement.
- **Proof of health insurance -**
A copy of your Medicare, Medicaid, or Private Insurance card. If you do not have health insurance, please note that on the application.

If applying for an Access to Care Account, please provide:

- **Proof of Georgia residency during the last six (6) months prior to the application date -**
Proof of residency can be 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 or 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.
- **Proof of current income -**
Proof can be in the form of your most recent State Income Tax return, most recent check stub or a Social Security Income statement.
- **Proof of health insurance -**
A 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 THE ABOVE REQUIRED DOCUMENTS

IF APPLYING FOR THE ACCESS TO CARE MATCHED ACCOUNT, please write your initials next to each statement to indicate that you understand the following before submitting this application:

- _____ I understand that if my application for a MATCHED account is approved, I will be reimbursed and matched AFTER the 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.
 - Medical bills and co-pays related to my transplant, subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses during my transplant for one (1) caregiver subject to \$1,000.00 maximum if in the matched program.
 - Travel, lodging and food expenses for my follow-up medical examinations for up to *six (6) months post-transplant*, subject to \$1,000.00 maximum if in the matched program.

Applicant's Signature _____ Date _____

Please Print Name _____

Phone Number _____

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

Please mail application and supporting documents to:

Georgia Transplant Foundation, 6600 Peachtree Dunwoody Road, Building 600, Suite 250, Atlanta GA 30328, Attn: TFP

1-866-428-9411

770-457-3796

Fax 770-457-7916

email: TFP@gatransplant.org