



# 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	
_____				_____	
Street Address				Apt/ Suite Number	
_____		_____		_____	
City		State		Zip Code	
_____		_____		_____	
Home Phone		Cell Phone		E-mail Address	
_____		_____		_____	
___ Male ___ Female		Marital Status _____		Spouse's Name _____	
_____		_____		_____	
Date of Birth		Age		Social Security Number	
_____		_____		_____	
		Number in Household		Number of Children (living in household)	

### DEMOGRAPHIC INFORMATION:

_____		_____		_____	
Transplant Center		Date of Transplant		Organ	
_____					
Follow-up Care					
<b>Race</b> Optional (Please Check): ___ Hispanic ___ African American ___ Black ___ White, Non-Hispanic					
___ Asian-American ___ Asian-Pacific Islander ___ Native American ___ Other					
<b>Level of Education</b> Optional (Please Check): ___ GED, ___ attended High School (number of years ___),					
___ High School Graduate, ___ Technical Certificate / Diploma, College (number of years ___),					
___ Associates, ___ Bachelors, ___ Masters, ___ PhD					
<b>Current Source of Income:</b> (Please check all that apply) ___ Full time employment ___ with benefits					
___ Part-time employment ___ with benefits, ___ Retirement pension, ___ Working spouse,					
___ Parent Income, ___ Social Security Retirement, ___ Social Security Disability (SSDI),					
___ Supplemental Security Income (SSI)					
<b>Work Status</b> (Please check): ___ Currently employed, Employer Name _____					
___ Medically Disabled _____, ___ Retired, ___ Unemployed _____					
		Date		Date	
<b>Current Source of Healthcare Coverage:</b> (Please check all that apply) ___ Insurance ___ Spouse's Insurance					
___ Parent's Insurance ___ Medicare ___ Medicaid ___ QMB Medicaid ___ Spend-down Medicaid ___ COBRA					

### Check all that apply:

- 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 \_\_\_\_\_

## 2009 FINANCIAL ASSISTANCE APPLICATION

DO NOT LEAVE ANY FIELD BLANK

**ASSETS**

ACCOUNTS:  
 CHECKING \$ \_\_\_\_\_  
 SAVINGS \$ \_\_\_\_\_

AUTOMOBILES:  
 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**

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)	\$ _____
_____	\$ _____
_____	\$ _____
<b><u>TOTAL MONTHLY INCOME</u></b>	<b>\$ _____</b>

**MONTHLY HOUSEHOLD EXPENSES**

RENT* <input type="checkbox"/> MORTGAGE* <input type="checkbox"/>	\$ _____
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 _____	\$ _____
<b><u>TOTAL MONTHLY EXPENSES*</u></b>	<b>\$ _____</b>

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: \_\_\_\_\_

