



# 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 County

\_\_\_\_\_  
 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

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, \_\_\_\_ Retirement pension, \_\_\_\_ Working spouse,  
 \_\_\_\_ Parent Income, \_\_\_\_ 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  
 \_\_\_\_ 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 LIVING DONOR ASSISTANCE APPLICATION**

DO NOT LEAVE ANY FIELD BLANK

**ASSETS**

ACCOUNTS:		AUTOMOBILES:	
CHECKING	\$ _____	YEAR _____	YEAR _____
SAVINGS	\$ _____	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	MONTHLY HOUSEHOLD EXPENSES
WAGES (net) \$ _____	RENT* <input type="checkbox"/> MORTGAGE* <input type="checkbox"/> \$ _____
SOC.SEC.(SSDI, SSI) \$ _____	FOOD \$ _____
ADDITIONAL DISABILITY \$ _____	UTILITIES \$ _____
PENSION \$ _____	TELEPHONE \$ _____
SPOUSE'S INCOME \$ _____	GAS & ELECTRICITY \$ _____
FAMILY MEMBER'S INCOME \$ _____	CELL PHONE \$ _____
TANF \$ _____	WATER \$ _____
VETERAN'S PENSION \$ _____	TRANSPORTATION \$ _____
RENTAL INCOME \$ _____	AUTO PAYMENT \$ _____
RETIREMENT INCOME \$ _____	GASOLINE \$ _____
DIVIDENDS \$ _____	MEDICAL EXPENSES \$ _____
OTHER (SPECIFY) \$ _____	DOCTORS FEES \$ _____
_____ \$ _____	HOSPITAL PAYMENTS \$ _____
_____ \$ _____	MEDICATIONS \$ _____
<b><u>TOTAL MONTHLY INCOME</u></b> \$ _____	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> \$ _____

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: \_\_\_\_\_

**2009 LIVING DONOR ASSISTANCE APPLICATION**

Transplant Recipient Name \_\_\_\_\_

Donor's Relationship To Recipient \_\_\_\_\_

Occupation \_\_\_\_\_ Estimated Recovery Time \_\_\_\_\_

Eligible Sick Leave (# Days) \_\_\_\_\_ Eligible Disability (# Days) \_\_\_\_\_

Donor's Health Insurance \_\_\_\_\_

Do you expect to have changes in your household income because you are donating?     Yes     No

Please explain changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What have you done to plan for the financial concerns related to loss of work?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How will other family members help you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there additional expenses outside of your normal budget that you will have as a result of donation? Please describe.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Assistance through the living donor program is based on your financial need and hardship specifically resulting from donating an organ. Please give us any additional information that outlines your circumstances and the need for assistance from GTF.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

