APPLICATION PACKET AND PROGRAM INFORMATION
The mission of the Georgia Transplant Foundation (GTF) is to help meet the needs of organ transplant candidates, recipients, living donors and their families by providing information and education regarding organ transplantation, granting financial assistance and being an advocate for sustaining and enriching lives everyday.
Dear Transplant Candidate:

Each year, the Georgia Transplant Foundation (GTF) helps more than 2,000 solid organ transplant candidates, recipients, and their families statewide by providing financial, educational and emotional support to go through the life changing experience of transplantation.

GTF staff is available to answer your questions and guide you through your fundraising process. Some of the services we offer are:

- Accounts with matched funds up to $10,000
- Unmatched accounts
- Monthly fundraising workshops
- GTF based personal webpages for fundraising
- Option of having post-transplant prescription medication expenses directly billed to your GTF account from a GTF-approved pharmacy

Because GTF is the trustee of the account, money raised is not considered a personal asset and does not jeopardize your participation in government assistance programs. Donations made to your account are not tax-deductible.

To apply to the Transplant Fundraising Program for a Matched or Unmatched account, please complete the enclosed application and mail it to GTF, 500 Sugar Mill Road, Suite 170-A, Atlanta, GA 30350. Once we receive your completed application, it will be reviewed and you will be notified of your status within 30 business days.

Should you have any questions or concerns, please feel free to call us at 1-866-428-9411. We look forward to working with you.

Cordially,

Nicole Townsend
Manager, Transplant Fundraising Program
770-457-3796 (Telephone)
770-457-7916 (Fax)
TFP@gatransplant.org (E-Mail)
Transplant Fundraising Program Introduction

The Transplant Fundraising Program (TFP) has been developed by the Georgia Transplant Foundation (GTF) to assist transplant candidates and recipients in financially preparing for ongoing costs associated with transplantation, primarily medication costs.

These accounts provide fundraising assistance and account management for transplant funds. Financial contributions are overseen by GTF staff and an Advisory Council that provides fiscal accountability to transplant clients and their contributors. In addition, detailed information about transplant accounts, including disbursements and contributions, are available upon request and are mailed out quarterly.

GTF offers two types of accounts:

**Matched** accounts provide up to a maximum of a $10,000 match and are used primarily for prescription medication costs. This type of account must be applied for and approved pre-transplant. Matched accounts are provided for fundraising dollars but have eligibility criteria, including: being a Georgia resident, applying pre-transplant, and exhibiting financial or insurance need. Clients with this type of account have one-year from their application approval date to raise funds eligible for the match (a maximum of $10,000). Please note: you are reimbursed and matched AFTER the transplant, once you begin to buy/pay for your prescription post-transplant medications and/or approved post-transplant related expenses. You must have a fundraising account held at GTF to be eligible for the match.

**Unmatched** accounts are NOT matched. Unmatched accounts may be opened pre- or post- transplant and funds may be used for expanded transplant costs such as housing and travel as well as prescription medication expenses. You must have a fundraising account held at GTF to be eligible for this account.

**Both Programs Offer:**
- On-going fundraising advice
- Monthly fundraising workshops
- GTF based personal webpage for fundraising**
- Availability for online donations by credit card
- Reimbursements processed within thirty (30) business days of receipt
- Option of having post transplant medication and/or medication co-pays directly billed from a GTF-approved pharmacy to your GTF account

* GTF charges a 3% administrative fee for each deposit made to your GTF account.

**There is a minimal bank fee of an average of 2.85% per transaction charged to the TFP client for credit card donations.
Application Process

**Step 1** - Fill out the application completely (at the back of this booklet). INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED. Once you have completed the application, mail it to the Georgia Transplant Foundation at the address listed on the last page of the application.

You *must* include the following items with your application:

**For a Matched Account:**
- Proof of Georgia residency during the last six (6) months prior to the application date
- Proof of current income
- Proof of all health insurance

**For an Unmatched Account:**
- Proof of Georgia residency. If you do not reside in Georgia, provide proof that you are being transplanted in a hospital in Georgia
- Proof of current income
- Proof of all health insurance

**Step 2** - GTF contacts your transplant center to verify your transplant status.

**Step 3** - After the transplant center verifies transplant status, the completed application goes to a Review Committee.

**Step 4** - After the committee meets and reviews the application, a letter is mailed to your mailing address (as indicated on the application) within thirty (30) business days regarding approval status.

**Step 5** - If approved, you are required to sign and mail back a client agreement agreeing to the terms and conditions of the Transplant Fundraising Program. **You are not enrolled in the program if the signed contract is not mailed back to GTF.** All of this must be completed pre-transplant for a matched account.

**Step 6** - Once GTF receives your signed contract, your account will be activated. You will then receive your welcome kit containing additional information regarding TFP, for example, how to make deposits, how friends and family can donate, how to set up your GTF personal webpage and other important information.
Deposit Funds Into Your GTF Account

Once you have been accepted into the Transplant Fundraising Program, your GTF account is opened and is ready to be used. There are three different ways to deposit money into your GTF (matched or unmatched) account:

1. Blue envelopes from the client
   Once your fundraising account is set up, you will be provided blue deposit envelopes for sending in funds. **These blue envelopes are for TFP clients use only, not their contributors.** GTF will not mail acknowledgement (thank you) letters to the contributors of the checks/money orders mailed in the blue envelopes because it will assume that the client has received the checks/money orders first and has already acknowledged the donor with a letter of thanks.

2. From a third-party mailing
   Any money sent to GTF in your honor, by a third party, will be deposited in your GTF account. All checks should be made out to Georgia Transplant Foundation with the memo section noting: “In Honor of (your name).” Checks should be mailed to GTF, 500 Sugar Mill Road, Suite 170-A, Atlanta, GA 30350. GTF will send a letter of acknowledgment for the contributions that are received directly in the GTF office.

3. Personal GTF webpage
   Once you have been accepted into the program, you will be given information on how to set up your personal GTF-based webpage. You will be able to direct friends and family to this page to make online donations directly into your GTF account and to find out more information about your upcoming fundraising events.

**Please note that gifts made online by credit card will be subject to a minimum processing fee by the bank of 2.85% per transaction.**

- Deposits can be made by check, money order, or credit card online. No cash will be accepted.
- GTF charges a 3% administrative fee for each deposit made to your GTF account.

It is your responsibility to inform the TFP program administrators of any change of contact information i.e. phone number, address, change of transplant center, etc.
Transplant-Related Expenses

To decide if the Transplant Fundraising Program is appropriate for you, preview the transplant-related expenses listed below that can be reimbursed from your account. Please note that the matched account is to be used primarily for post-transplant prescription medication expenses. The following are considered reasonable transplant-related expenses for which funds may be used as outlined in Transplant Fundraising Program guidelines:

<table>
<thead>
<tr>
<th>Definition of “Transplant-Related Expenses”</th>
<th>Matched Account</th>
<th>Unmatched Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-transplant expenses are defined as those reasonable expenses caused after the transplant has occurred.</td>
<td>Pre- and post-transplant expenses are defined as those reasonable expenses caused by the need for transplant and the transplant expenses incurred after the transplant has occurred.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasonable Transplant-Related Expenses</th>
<th>Matched Account</th>
<th>Unmatched Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Post-transplant prescription medications necessitated by the transplant for the client</td>
<td>• Prescription medications necessitated by the transplant for the client</td>
<td></td>
</tr>
<tr>
<td>• Medical bills, co-pays, travel and lodging related to transplant care for the client, subject to $1,000 maximum</td>
<td>• Medical bills and co-pays related to the transplant for the client</td>
<td></td>
</tr>
<tr>
<td>• Please note that the total maximum reimbursement for post-transplant related expenses other than prescription medication is $1,000</td>
<td>• Travel and lodging expenses during the client’s transplant for the caregiver</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Travel and lodging expenses for the client’s follow-up medical examinations</td>
<td></td>
</tr>
</tbody>
</table>

Specific transplant costs outside of these guidelines can be considered and must be requested in writing at the time the Transplant Fundraising Program application is submitted. This request must be pre-approved. GTF specifically reserves the right in its sole discretion to pay only those expenses that it deems appropriate. You must seek reimbursement and utilize coverage under all insurance plans and government programs such as Medicare and Medicaid, before utilizing the funds in your GTF account.

These items are not considered transplant expenses and will not be reimbursed (this is not a complete list):

- Automotive repairs and maintenance
- School expenses, learning aids, tuition or camp fees
- Health club memberships or exercise equipment
- Postage
- Rehab therapy not administered by a licensed therapist
- Interest or finance charges
- Personal products
- Treatment taking place outside of the US
- Tobacco products or alcoholic beverages
- Treatment taking place outside of the US
- Non-prescribed medicine
- Entertainment items (videos and toys)
- Loss of income
- Clothing
- Any taxes due
- Legal fees
- Expenses unrelated to transplant

The final decision on eligibility rests with Georgia Transplant Foundation staff and the Transplant Fundraising Program Advisory Council. Please refer any questions regarding eligibility and reimbursement to the Transplant Fundraising Program staff at TFP@gatransplant.org or 770-457-3796.
Reimbursement of Expenses

**General Reimbursement Guidelines**
- All expenses to be reimbursed must be submitted with the TFP Reimbursement Request Form.
- The original itemized receipt for all expenses submitted. A detailed receipt must accompany credit card receipts.
- Receipts must be submitted within three (3) months.
- All requests must be submitted in a neat and organized fashion.
- All payments are contingent upon the amount of money in the client’s account.
- The turn-around time for reimbursement is approximately thirty (30) business days after GTF receives the completed request.
- The client, client’s volunteers and Georgia Transplant Foundation has a fiduciary responsibility to ensure that the money raised/deposited is used in the manner in which it was solicited.

**REIMBURSEMENT FOR MEDICATION COSTS AND POST-TRANSPLANT RELATED EXPENSES**

**DIRECT PHARMACY BILLING**
So that you don’t have to pay up front and wait for reimbursement, the Georgia Transplant Foundation has a partnership with a GTF-approved pharmacy to supply your prescription medications, bill your insurance or Medicare/Medicaid and then bill your TFP account. *If you would like to take advantage of this program please indicate your preference on page 17 of the application and let your transplant team know your pharmacy preference when you are transplanted.*

**STEP 1**
You pay for your prescription medications and non-prescription medicine expenses

**STEP 2**
Fill out your TFP Reimbursement form neatly and attach receipts/proof of payment

**STEP 3**
Mail forms to GTF

**STEP 4**
GTF processes request and mails your reimbursement within 30 business days

All requests for funds for reimbursement must be submitted within three (3) months of expenditure, in writing and using the TFP Reimbursement Request Form accompanied by appropriate receipts/proof of payment.

GTF has no obligation to pay more expenses than it has money available in the specified account.
### Accounting For Funds

GTF maintains audited financial records assuring fiscal accountability for money received and disbursed.

These funds will be disbursed by GTF for your transplant related expenses. Please reference GTF information for approved transplant related expenses.

GTF staff will oversee the deposits, administration and disbursement of all contributions.

In order to help defray the cost of its services, GTF will retain the interest earned on funds deposited.

GTF will maintain complete and accurate records of all funds raised and will provide a quarterly statement of all funds donated directly to GTF in honor of a client, all funds disbursed and any applicable bank fees. Please note the client will receive a quarterly statement only if the account had any activity (deposits/donations/disbursements) during the previous quarter. **Account balances will not be given by telephone.**

We acknowledge that all funds raised for the transplant have been donated by the patient, family, friends and/or the public, and that both the patient/client and GTF will be held strictly accountable by the public for all funds raised.

### Not Transplanted, Too Sick To Transplant, or Failure to Survive

**Untransplantable**

In the event that a TFP client is not transplanted, becomes too sick to transplant, or recovers, all money remaining will be transferred to an **unmatched** account where unpaid, legitimate medical expenses will be reviewed for payment. **These reimbursements are not matched by GTF funds.** Legitimate medical expenses include prescription medication/co-pays, hospital deductibles/co-pays, doctor’s co-pays, COBRA payments and insurance premiums.

**Deceased**

In the event that a TFP client passes away, all money remaining will be transferred into an **unmatched** account. The person authorized to request withdrawals, as indicated on the TFP Client Agreement, may submit a request for eligible medical expenses for a period of three (3) months after a client’s death.

The GTF Advisory Council may disburse up to a maximum of $5,000 towards funeral expenses paid directly to the funeral home. This disbursement is based on funds available in the client’s account and it is not matched by GTF.

Based on review of need, GTF will consider paying mortgage or rent for the client’s primary residence on file with GTF for one (1) month after the death of a client. This request must be in writing and proof of financial need must be demonstrated. This is not matched by GTF.

Should there be any funds remaining in your account following the above disbursements, the Advisory Council will authorize the transfer of funds to support the Georgia Transplant Foundation. These funds shall remain the property of the Georgia Transplant Foundation.

Funds disbursed under these guidelines are taken from the balance of your TFP account and are not eligible for GTF match. The above items are only payable to the extent there are funds in your TFP account.
### Client Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Apartment/Unit#</td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>E-mail</td>
<td></td>
</tr>
<tr>
<td>Male □ Female □</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td>Spouse's Name (if applicable)</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Age</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Age</td>
</tr>
<tr>
<td>Date of Transplant (if applicable)</td>
<td>Organ</td>
</tr>
<tr>
<td>Date of Transplant (if applicable)</td>
<td>Transplant Center</td>
</tr>
</tbody>
</table>

### Demographic Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race (optional - please check)</td>
<td>□ Hispanic □ African American □ Black □ White, Non-Hispanic □ Asian-American □ Asian-Pacific Islander □ Native American □ Other ____________________</td>
</tr>
<tr>
<td>Level of Education (optional - please check)</td>
<td>□ GED □ Attended High School (# of years _____) □ High School Graduate □ Technical Certificate/Diploma □ Currently Enrolled in College □ Attended College (# of years _____) □ Associates Degree □ Bachelors Degree □ Post-Graduate Degree □ Other ____________________</td>
</tr>
<tr>
<td>Work Status (please check)</td>
<td>□ Currently Employed; Employer Name __________________________</td>
</tr>
<tr>
<td></td>
<td>□ Medically Disabled □ Retired □ Unemployed ____________________</td>
</tr>
<tr>
<td>Current Source of Healthcare Coverage (please check all that apply)</td>
<td>□ Insurance (please circle: BCBS; United Healthcare; Humana; Kaiser; Aetna; Other __________) □ Spouse's Insurance □ Medicare □ Medicaid □ QMB Medicaid □ Spend-down Medicaid □ COBRA</td>
</tr>
<tr>
<td>Check all that apply to you:</td>
<td>□ Recipient □ Candidate □ Living Donor □ JumpStart Client □ Trends In Transplant (TNT) Conference Attendee □ Fundraising Workshop Attendee □ Mentor/Mentee □ GTF Volunteer/ Board Member/ Committee Member</td>
</tr>
<tr>
<td>How did you hear about GTF services?</td>
<td>□ GTF Website/ IMPRINT Magazine/ Brochure □ GTF Staff, Name ____________________</td>
</tr>
<tr>
<td></td>
<td>□ GTF Volunteer, Name ______________________</td>
</tr>
<tr>
<td></td>
<td>□ Transplant Center Staff, Name ____________________</td>
</tr>
</tbody>
</table>
**PART ONE - TRANSPLANT CENTER INFORMATION**

<table>
<thead>
<tr>
<th>Transplant Center</th>
<th>Organ Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Financial Coordinator/Social Worker**

**I am:**
- [ ] Currently being evaluated for transplant
- [ ] Listed for transplant
- [ ] Transplanted (Date) ______________

**I am raising funds for:**
- [ ] Prescription Medications
- [ ] Other Transplant-Related Costs

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**PART TWO - INSURANCE INFORMATION**

If you have questions about your coverage, please contact your insurance company or transplant center financial coordinator/social worker.

<table>
<thead>
<tr>
<th>Type of Coverage:</th>
<th>Medicare</th>
<th>Medicare Advantage</th>
<th>Medicare Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] A</td>
<td>[ ] B</td>
<td>[ ] D</td>
</tr>
</tbody>
</table>

- [ ] Katie Beckett
- [ ] Medicaid
- [ ] Medicaid Spend-Down
- [ ] QMB Medicaid

<table>
<thead>
<tr>
<th>Insurance:</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you have this coverage?</th>
<th>[ ] ESRD</th>
<th>[ ] My Employment</th>
<th>[ ] Spouse's Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] COBRA</td>
<td>[ ] Retirement</td>
<td>[ ] Disabled</td>
</tr>
</tbody>
</table>

**What does your insurance cover for transplant?** (please answer below)

- **Medicare**
  - Annual Deductable: ______________
  - Annual Out-of-Pocket Maximum: ______________
  - Annual Maximum Benefit: ______________
  - Lifetime Maximum Benefit: ______________
  - Immunosuppressant Co-Payments (Estimate): ___________/month

- **Medicare**
  - Annual Deductable: ______________
  - Part A ______________
  - Part B ______________
  - Part D ______________

**Immunosuppressant Co-Payments: ___________/month**

**What other non-medical expenses are anticipated?** (please check all that may apply)

- [ ] Insurance premiums
- [ ] Lodging for patient/caregiver who needs to stay local post-transplant
- [ ] Parking
- [ ] Transportation/fuel
- [ ] Child care
- [ ] Other ____________________________

**Will there be ANY changes in your insurance coverage after your transplant?** (please explain)

- [ ] Eligible for/accepting Medicare benefits on: __________________________
- [ ] Medicare terminates 3 years post-transplant (kidney)
- [ ] COBRA benefits terminate on: __________________________
- [ ] Insurance is dependent on disability status
- [ ] Other: ____________________________
Name___________________________________________________

PLEASE ANSWER ALL QUESTIONS FOR THE REVIEW COMMITTEE

**PART THREE - FINANCIAL INFORMATION**

<table>
<thead>
<tr>
<th>ASSETS:</th>
<th>AUTOMOBILE(S):</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHECKING</td>
<td>YEAR __________</td>
</tr>
<tr>
<td>SAVINGS</td>
<td>YEAR __________</td>
</tr>
<tr>
<td>STOCKS &amp; BONDS</td>
<td>MAKE __________</td>
</tr>
<tr>
<td>RETIREMENT ACCOUNTS</td>
<td>MAKE __________</td>
</tr>
</tbody>
</table>

Household: All people living in your home (includes all children and/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)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAGES (net)</td>
<td>$</td>
</tr>
<tr>
<td>SPOUSE'S INCOME</td>
<td>$</td>
</tr>
<tr>
<td>FAMILY MEMBER'S INCOME</td>
<td>$</td>
</tr>
<tr>
<td>SOCIAL SECURITY (SSDI, SSI)</td>
<td>$</td>
</tr>
<tr>
<td>ADDITIONAL DISABILITY</td>
<td>$</td>
</tr>
<tr>
<td>PENSION</td>
<td>$</td>
</tr>
<tr>
<td>RETIREMENT INCOME</td>
<td>$</td>
</tr>
<tr>
<td>VETERAN’S PENSION</td>
<td>$</td>
</tr>
<tr>
<td>TANF</td>
<td>$</td>
</tr>
<tr>
<td>FOOD STAMPS</td>
<td>$</td>
</tr>
<tr>
<td>RENTAL</td>
<td>$</td>
</tr>
<tr>
<td>DIVIDENDS</td>
<td>$</td>
</tr>
<tr>
<td>OTHER</td>
<td>$</td>
</tr>
</tbody>
</table>

**TOTAL MONTHLY INCOME**

$_______

**MONTHLY HOUSEHOLD EXPENSES**

(please read above description)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>RENT*</td>
<td>$</td>
</tr>
<tr>
<td>MORTGAGE*</td>
<td>$</td>
</tr>
<tr>
<td>FOOD</td>
<td>$</td>
</tr>
<tr>
<td>UTILITIES</td>
<td>$</td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>$</td>
</tr>
<tr>
<td>GAS &amp; ELECTRICITY</td>
<td>$</td>
</tr>
<tr>
<td>CELL PHONE</td>
<td>$</td>
</tr>
<tr>
<td>WATER</td>
<td>$</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>$</td>
</tr>
<tr>
<td>PUBLIC TRANSPORTATION</td>
<td>$</td>
</tr>
<tr>
<td>AUTO PAYMENT</td>
<td>$</td>
</tr>
<tr>
<td>GASOLINE</td>
<td>$</td>
</tr>
<tr>
<td>MEDICAL EXPENSES</td>
<td>$</td>
</tr>
<tr>
<td>DOCTORS FEES</td>
<td>$</td>
</tr>
<tr>
<td>HOSPITAL PAYMENTS</td>
<td>$</td>
</tr>
<tr>
<td>MEDICATIONS</td>
<td>$</td>
</tr>
<tr>
<td>DENTAL</td>
<td>$</td>
</tr>
<tr>
<td>INSURANCE</td>
<td>$</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>$</td>
</tr>
<tr>
<td>LIFE</td>
<td>$</td>
</tr>
<tr>
<td>AUTO</td>
<td>$</td>
</tr>
<tr>
<td>CHARGE ACCOUNTS</td>
<td>$</td>
</tr>
<tr>
<td>BANK CARDS (monthly payment)</td>
<td>$</td>
</tr>
<tr>
<td>OTHER</td>
<td>$</td>
</tr>
<tr>
<td>OTHER</td>
<td>$</td>
</tr>
</tbody>
</table>

**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?  □ Yes  □ No

What have you done to plan for your transplant?

Have you already raised funds?  □ Yes  □ No  If so, how much?

Have you attended GTF’s Fundraising Workshop?  □ Yes  □ No

GTF conducts Fundraising Workshops throughout the year. Please call 1-866-428-9411 or visit our website (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 ACCOUNT - this account is matched by GTF
  ● Funds raised within one (1) year of acceptance into the Program are matched up to a maximum of $10,000.
  ● Must be accepted into the Program pre-transplant.
  ● Funds are limited to $1,000 for non-prescription medication costs.
  ● GTF charges a 3% administrative fee for each deposit made to the account.

  OR

☐ UNMATCHED ACCOUNT - this account is NOT matched
  ● Eligible to apply pre- or post- transplant.
  ● Funds are available for reasonable pre- and post- transplant expenses.
  ● Expanded limits on non-prescription medication transplant-related costs.
  ● GTF charges a 3% administrative fee for each deposit made to the account.

☐ Direct Pharmacy Billing (OPTIONAL) I would like to use the direct billing process for my post-transplant prescription medications. Prescription medications are supplied by a GTF-approved pharmacy. This process will allow the GTF-approved pharmacy to bill my insurance, Medicare or Medicaid for the cost of my post-transplant prescription medications. The balance or co-pay will then be directly taken from my TFP account. This process will allow me to have my fundraising account directly billed so that I do not have to pay upfront for my prescription medications. 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 the pharmacy directly as needed.

MANDATORY: In addition to yourself, please identify who is authorized 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 Code: _________________________

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 ISSUE date of six (6) months older than the application date (the issue date is located next to your date of birth), a **six (6) month old** utility bill, a **six (6) month old** bank statement, a letter from your dialysis or transplant center stating that you have been a patient there for six (6) months. This document should include your name, current address and a date six (6) months prior to the date you are completing the application.

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

➤Proof of health insurance
A front and back copy of your Medicare, Medicaid, and/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 A MATCHED account, 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 post-transplant prescription medications and/or approved post-transplant related expenses.

__________________________ I understand that if my application for a MATCHED account is approved, GTF charges a 3% administrative fee for each deposit made into my account.

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

- Prescription medications necessitated by my transplant.
- A total of $1,000 for any of the following categories combined:
  - Medical bills and co-pays related to my transplant, and/or
  - Travel and lodging expenses during my transplant for one (1) caregiver and/or
  - Travel and lodging expenses for my follow-up medical care

Applicant’s Signature ___________________________________________ Date ____________________

Print Name _____________________________________________ Phone Number ____________________

If you need assistance completing this application or to answer any questions, please contact the Georgia Transplant Foundation (TFP@gatransplant.org, 1-866-428-9411 or 770-457-3796).

Please mail your completed application and supporting documents to:

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