Transplant Fundraising Application Check List

Please note that your Transplant Fundraising Program Application is not complete without the receipt of the following items:

- ☐ Completed TFP Application

- ☐ Proof of Health Insurance
  Copy of the back and front of your insurance card.

- ☐ Proof of Household Income
  Copy of paystubs for each member of the household, or
  Copy of bank statements showing direct deposits for every member of the household, and/or
  Copy of award statement.

- ☐ Proof of Georgia Residency
  Copy of Georgia Drivers License or State ID (atleast six (6) months old), or
  Utility bill showing address dated as of six (6) months prior to the application date.

- ☐ Please submit your completed application and all of your supporting documents

  By Mail: Georgia Transplant Foundation
  Attn: TFP
  2201 Macy Drive
  Roswell, GA 30076

  By Fax: (678) 666-1371

  By Email: TFP@gatransplant.org

TRANSPLANT FUNDRAISING APPLICATION

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

Georgia Transplant Foundation
Enriching Lives Everyday

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 | # Adults in Household | # Children 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 ☐ Post-Graduate Degree ☐ Other _____

Work Status (please check) ☐ Currently Employed; Employer Name _____
☐ Medically Disabled _____ Date ☐ Retired _____ Date ☐ Unemployed _____ Date

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

Current Source of Healthcare Coverage (please check all that apply)
☐ Insurance (please circle: BCBS; United Healthcare; Humana; Kaiser; Aetna; 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/Mentee ☐ 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

Transplant Center		**Organ Needed**	
Financial Coordinator/Social Worker			
I am:	☐ Currently being evaluated for transplant	☐ Listed for transplant	☐ Transplanted (Date) _____
I am raising funds for:	☐ Prescription Medications	☐ Medical Insurance Premiums	☐ Other Transplant-Related Costs

PART TWO - INSURANCE INFORMATION

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

Medical Insurance: Primary _____ Secondary _____

Type of Coverage: Medicare ☐ A ☐ B ☐ D ☐ Medicare Advantage ☐ Medicare Supplement _____

☐ Katie Beckett ☐ Medicaid ☐ Medicaid Spend-Down ☐ QMB Medicaid

How do you have this coverage? ☐ ESRD ☐ My Employment ☐ Spouse's Employment ☐ Private Policy

☐ COBRA ☐ Retirement ☐ Disabled ☐ Other _____

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

Annual Deductible: $_____

Annual Out-of-Pocket Maximum: $_____

Annual Maximum Benefit: $_____

Lifetime Maximum Benefit: $_____

Immunosuppressant Co-Payments (Estimate): $_____ /month

Medicare Annual Deductible:

Part A: $_____

Part B: $_____

Part D: $_____

Immunosuppressant Co-Payments: $_____ /month

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

☐ Eligible for/accepting Medicare benefits on: _____

☐ Medicare terminates three (3) years post-transplant (kidney)

☐ COBRA benefits terminate on: _____

☐ Insurance is dependent on disability status

☐ Other: _____

PART THREE - FUNDRAISING

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 attended GTF's Fundraising Workshop? ☐ **Yes** ☐ **No**

GTF conducts Fundraising Workshops throughout the year. Please visit www.gatransplant.org for Fundraising Workshop dates.

Name_____

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

PART FOUR - 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 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)

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	**$**

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**

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**	**$**

*** 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 FIVE - TRANSPLANT FUNDRAISING PROGRAM SELECTIONS

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

☐ **MATCHED ACCOUNT**

- 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.
- Medical insurance premiums are not subject to $1,000 limit.
- GTF charges a 3% administrative fee for each deposit made to the account.

OR

☐ **UNMATCHED ACCOUNT**

- 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.

PART SIX - PHARMACY OPTIONS

Please choose **ONE** pharmacy option.

☐ I _____(full name) **choose 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.

☐ I _____(full name) **do not choose** to participate in Direct Billing with any of the Georgia Transplant Foundation's partner pharmacies at this time. I understand that this choice means that I will have to pay for my prescriptions out of pocket at time of refill and be reimbursed from my TFP account at a later time.

PART SEVEN - REQUIRED AUTHORIZATION

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: _____ **Email:** _____

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), OR a **six (6) month old** utility bill, OR a **six (6) month old** bank statement, OR 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 household income at the time of your application

Proof can be in the form of your most recent pay check stub, OR a Social Security Income statement, OR a bank statement showing monthly Social Security check deposit, OR your most recent Federal Income Tax return for all adult members of your household.

➔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

Please sign your initials next to **each** statement to indicate that you understand the following:

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

_____ I understand that if my application for a TFP fundraising 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 and medical insurance premiums.

_____ I understand that if my application for a TFP Matched Account is approved, I will be reimbursed and matched for the following:

- Prescription medications necessitated by my transplant.
- Medical insurance premiums.
- A combined total of $1,000 for any of the following catagories:
  - 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** _____

Email Address _____

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 678-514-1170).

Please mail your completed application and supporting documents to:

Georgia Transplant Foundation
Attn: TFP
2201 Macy Drive
Roswell, GA 30076

or by fax to (678) 666-1371