EVALUATION ASSISTANCE

For Dialysis Center or Transplant Staff Only

NEED: Potential candidates for transplant must travel to the hospital for evaluation in order to be listed for a transplant. These potential candidates often lack the resources to afford fuel and lodging costs associated with this travel.

OBJECTIVE: The goal of the Evaluation Assistance Program is to provide access to transplantation by offering financial support to residents of Georgia who are seeking transplant evaluation or re-evaluation.

GUIDELINES:

- Georgia Resident - Legal permanent resident of Georgia

- Eligible Persons – Potential candidates for transplant who have evaluations scheduled and live at least 75 miles away from the transplant center. Candidates are eligible to receive Evaluation Assistance **a maximum of two times**. This assistance can be used for:
    1) evaluation at two separate centers
    2) an initial evaluation and a follow-up/re-evaluation at the same center

- Grant Limitation - Grants are available to assist with lodging, fuel costs, and parking fees for appointments. All grants are based on evidence of financial need and must be pre-approved.

- Amount of Grant – GTF can assist with fuel costs and/or hotel expenses. Lodging assistance will be available at the rate of $100 per night, up to three nights, based on transplant center protocol. Any stays of more than three nights must utilize a GTF direct bill hotel. Fuel assistance will be based on the distance from the patient's home to the transplant center. Parking fees will be estimated and included with fuel assistance.

- Payment Method – If approved, notice will be given to the referring party. A check including hotel and transportation assistance will be issued, payable to the patient. The check will be mailed directly to the patient.

PROCESS

1. Potential candidate may be referred by dialysis center or transplant center staff.
2. Complete applications will include GTF application filled out by patient and Evaluation Assistance form fully completed by dialysis clinic or transplant center staff. Submitting staff member must verify evaluation dates with transplant center.
3. Applications may be submitted **no more than 30 days prior** to evaluation and will be reviewed within 10 business days of receipt. We are not able to reimburse after an evaluation has taken place.
4. Submitting dialysis center or transplant center staff will be notified of approval.
5. Check will be made payable to potential candidate and will be mailed to his/her home mailing address as indicated on application.
6. Hotel authorization will be faxed directly to hotel if using GTF direct bill hotel (for stays greater than 3 nights). Patient will follow-up with hotel to secure reservation.

Georgia Transplant Foundation, 2201 Macy Drive, Roswell, GA 30076
770-457-3796 866-428-9411 Assistance Applications Fax 770-212-2178

FINANCIAL ASSISTANCE 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 ☐ 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 _____

Patient's Name_____

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

PART THREE - 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 childrenor 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:**

Georgia Transplant Foundation

Enriching Lives Everyday

Evaluation Assistance

Today's Date: _____

Patient Name: _____

Patient Mailing Address: _____

If PO Box, list home address also. _____

City, State, Zip code: _____

Transplant Center: _____ Organ: _____

Dialysis Center (if applicable) _____

Scheduled evaluation date(s) _____

Distance one-way from home to transplant center _____
Via Google Maps or MapQuest

Dates hotel stay is needed _____

Has patient received GTF Evaluation Assistance before? Yes ☐ No ☐

Staff Statement of Need: _____

_____

_____

_____

Evaluation Appointment Verified by Staff Yes ☐ No ☐

_____
Dialysis or Transplant Center Staff Signature & Title Date

_____
Staff Email Address Staff Phone Number

For GTF use only

_____ X _____ = _____ ÷ _____ = _____ x _____ = _____
Miles Round Trip | Number of Trips | Miles per gallon | Gallons | Price per gallon | Cost

Transportation Stipend Amount: _____

GTF Approval: _____ _____
Signature Date

Check payable to: _____