

LIVING DONOR ASSISTANCE APPLICATION

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



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 _____

Living Donor'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 children 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 \$ _____

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** \$ _____

I authorize information released between GTR 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: _____

Living Donor's Name _____

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

Donor's 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 explain:	
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.	

