

Transplant Foundation, Inc. Donate Organs – Pass it On Patient Services Grant Guidelines

Transplant Foundation, Inc. funds projects of regional importance to advance the health and well being of transplant patients. The Foundation's grant making approach facilitates and supports efforts to improve the daily life of individuals with end stage organ disease and to fill the financial gap they may experience over the course of treatment. Often, even in situations where the patient has excellent insurance coverage, many costs associated with transplants are not covered by insurance and cause serious economic hardship. The Foundation offers **individual grants** that assist transplant patients.

Individual Grants are made in the following categories;

Housing * Medication * Transportation * Other emergencies

Individual Grant application requires the following information;

- Referrals must be made by a social worker, nurse, case worker or other healthcare provider currently familiar with his or her illness and family situation;
- The individual must have a diagnosed serious, chronic or critical illness, disability or condition requiring a transplant or be post transplant
- Further, the individual must be medically involved enough that he or she is currently being followed by a healthcare provider who is informed about the individual's condition.
- The individual must receive treatment from a Florida hospital.
- Financial status
- The Foundation's Patient Service Application Form and Grant Request for Patient Services must be filled out completely; all information requested is strictly confidential and required in order for us to process the application
- **Please contact Transplant Foundation at 1 866-900-3162. A staff person will be happy to help you.**

Transplant Foundation, Inc

701 SW 27th Avenue, Suite 705, Miami, Florida, Phone 305 817 5645, Fax 305 541 6500

www.transplantfoundation.org

Guidelines for Referring Social Workers & Other Health Care Professionals

To enable us to process your request promptly, please mail or fax:

1. A typed or hand printed Transplant Foundation Patient Services Application Form

Please be sure to provide all requested information or we would be unable to process your request. Please **type or hand print** clearly the Data Sheet since it is often difficult to read faxed names, addresses and account numbers with accuracy

2. Grant Request for Patient Services

3. Copies of all bills to be paid (if applicable)

Transplant Foundation is dedicated to providing patient services, educate the public about organ, tissue and eye donation and finance research. When you need a transplant to live you need a helping hand to survive.

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Patient Services Application Form

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 Number in household Number of Children

DEMOGRAPHIC INFORMATION:

Transplant Center Date of Transplant Organ

Follow-up Care

Race Option (Please Check): ____ Hispanic ____ African American ____ White, Non-Hispanic
____ Asian Pacific Islander ____ American Indian, Alaskan Native ____ 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),
____ Supplement Security Income (SSI)

TOTAL MONTHLY INCOME: _____

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 Mentor TF Volunteer/Board Member/Committee Member

How did you hear about TF Services? TF Website/Newsletter/Brochure _____
TF Staff... Name _____ TF Volunteer, Name _____
Transplant Center Staff, Name _____

**Transplant Foundation, Inc.
Grant Request for Patient Services**

Social Worker Name: _____

Hospital: _____

Email/Phone: _____

Patient's name: _____

Address: _____

Phone Number: _____

Type of Transplant: _____

Date of Transplant: _____

Amount Requested: _____

Request for: _____

Have you received help from Transplant Foundation before? If so, when: _____

Request made by: _____ **Telephone:** _____

Check made payable to: _____

Social Work Statement (reason for request): _____

Action taken to assist patient in future: _____

Signature: _____ **Date:** _____