A Gift of Life

Heart & Lung Transplant Support Group

Application for Financial Assistance

This form must be filled out completely and the requested documentation attached in order for Gift of Life to review it.

Personal Information

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Date of Birth:_____ Email Address: _____

Spouse Name: _____ Spouse's Occupation: _____ F/T P/T

Current Physician/Specialist: _____ Case/Social Worker name & Contact info: _____

Organ Transplant: Heart____ Lung____ Date_____ I am currently on the donor waiting list: YES_____ NO_____

Is it OK for us to leave a detailed message about this application on your voice mail or with another household member?
YES_____(Please put a * next to prefered phone number) NO_____

Financial Information

Current Household Income: $ _____/monthly Total # of Persons living in household: _____

Spouse's Income: $_____/monthly # Adults_____ # of Dependent Children_____

Supplemental Security Income(S.S.I) $ _____/monthly

Social Security Disability Insurance(S.S.D.I.) $_____/monthly

Other Income (pension, alimony, family support) $_____/monthly

VA Benefits: $_____ VA Member: YES _____ NO _____

Private Disability Insurance: $_____

Total Cash, Checking, Savings, and Assets (Excludes retirement plan funds, IRA, 401K, Home Equity) $_____

PLEASE ATTACH MOST CURRENT FEDERAL INCOME TAX RETURN

Medical Insurance: Please circle the appropriate response:

Medicare Medicaid VA Private Insurance No Insurance

Nature of Request

Financial assistance needed for (identify item/service) _____

Please attach receipts-Application will not be reviewed without documents requested

Total cost of item/service, if known $_____

Amount *you* can contribute $_____

Amount secured *from other community/family resources* $_____

List (3) other resources you have contacted, amount received from each or status of your request (including: medical insurance for medications)

1. _____
2. _____
3. _____

The above information is complete and true to the best of my knowledge. By submitting this application, I give the Gift Of Life Heart and Lung Transplant support group permission to obtain any further information relevant to this assistance request.

Signature:	Date:

Case worker name (please print): email:

Additional documentation or information may be requested to determine how best to address this request.

Please email this form to admin@agiftoflifecares.com or fax to: 203-220-6572

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