



Questionnaire & Agreement

National Foundation for Transplants (NFT) offers financial assistance through fundraising and grant programs to organ and tissue transplant candidates and recipients for transplant-related costs not covered by public or private insurance.

A completed **Agreement** is required to participate in NFT's program. A **letter** from your transplant professional or physician verifying your transplant status, a quality **patient photo** and **Your Story** are also needed. For program details, please refer to **NFT's Policies for Assistance**. For more information, please call NFT at 1-800-489-3863. For address information, please refer to the back of this form.

***Please print** in the spaces provided. If the patient is a minor, the questionnaire should be completed by the parent or legal guardian.*

Personal Information

Patient's Name _____ S.S.# _____ Date of Birth _____

Name as you want it to appear on campaign materials _____

Address _____

City _____ State _____ Zip _____ E-mail _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Employer _____ Occupation _____

Spouse's Name _____ Cell (_____) _____ E-mail _____

Spouse's Employer _____ Occupation _____

Do you have children? ____ Yes ____ No How many? ____ Ages? _____

NFT offers assistance to transplant patients who are transplanted in the United States. I attest that I am:

A citizen or national of the United States A lawful permanent resident An alien on medical or student visa

Medical Information

Type of transplant _____ Medical Diagnosis _____

For organ transplants: Are you on the waiting list? ____ Yes ____ No What was the transplant date? _____

If you need a bone marrow transplant, has a search been initiated? ____ Yes ____ No

Hospital where transplant will be/was performed _____

Financial Coordinator: _____ Phone (_____) _____

Social Worker's Name: _____ Phone (_____) _____

Transplant Coordinator: _____ Phone (_____) _____

Transplant Physician: _____ Phone (_____) _____

Insurance Information

Private Insurance: Yes No Insurance Company: _____

Is this a COBRA Plan? Yes No If yes, when will it expire? _____

Do you pay a portion of your insurance premium? Yes No If yes, monthly amount you pay \$ _____

What is your yearly deductible? \$ _____ If your policy has a lifetime maximum, how much is it? \$ _____

Does your health insurance cover:

- Transplant expenses? Yes () No
- Post-transplant medications? Yes () No
- Bone marrow donor search? Yes () No
- Travel, food or lodging expenses? Yes No; How much? _____

Are you Medicare approved? Yes No Do you also have Part A? Part B? Part D?

Do you have a supplemental plan? Yes No; If yes, Insurance Company: _____

Are you Medicaid approved? Yes No; If yes, please attach a copy of the front and back of your ID card.

Do you have a “spend down” or “share of cost” provision? Yes No; If yes, what is the amount? \$ _____

Please notify NFT of any future changes to your insurance, Medicare or Medicaid status.

Transplant Costs

To help estimate the patient’s transplant costs, please ask the transplant Financial Coordinator to assist you with this section.

Has your transplant professional informed you of the estimated costs of your transplant? Yes No

If yes, what is the **estimated total cost without insurance** (hospital, procurement and physicians) \$ _____

And what is your estimated out-of-pocket responsibility after insurance? \$ _____

Is there a deposit required by the hospital? Yes No; If so, what is the amount? \$ _____

Reason for deposit requirement: _____

What are your current monthly costs for pre-transplant medications? \$ _____

What are your estimated monthly costs for post-transplant medications? \$ _____

What are your estimated pre-transplant-related travel, food and lodging costs? \$ _____

What are your estimated post-transplant-related travel, food and lodging costs? \$ _____

Distance to your transplant center in miles: _____

What are your most pressing financial needs: _____

Do you have specific concerns that you wish to bring to our attention? _____

Financial Information

Assistance is based on NFT's Policy for Assistance. Income level alone is not an indicator of eligibility in NFT's fund-raising program. Please fill out the form below showing monthly income and expenses.

- If you are married, include income of both the husband and wife and all household expenses.
- If you are a dependent, include all household income and expenses.
- If you are not a dependent, but reside with other family members, only your income and expenses should be included.
- **If you are Medicaid approved, you may skip this financial information section. (Please attach copy of Medicaid ID card.)**

Average Monthly Income	
Salary/Wages – Net Taxes	\$ _____
Social Security Income	\$ _____
Disability Income	\$ _____
Retirement Income (Pension)	\$ _____
Withdrawal IRAs	\$ _____
Interest/Dividend Income	\$ _____
Public Assistance	\$ _____
Other Income (Specify)	\$ _____
_____	\$ _____
_____	\$ _____
Total Monthly Income:	\$ _____

Average Monthly Expenses	
Rent or Mortgage	\$ _____
Utilities (including gas, water, electric)	\$ _____
Other Household Expenses (including food, utilities, phone, cable, internet, etc.)	\$ _____
Auto Payments	\$ _____
Gasoline	\$ _____
Car Maintenance/Repairs	\$ _____
Medical (not covered by insurance) (including doctor fees, hospital payments, medications, etc.)	\$ _____
Health Insurance Premiums	\$ _____
Life Insurance	\$ _____
Car Insurance	\$ _____
Disability Insurance	\$ _____
Home Insurance	\$ _____
Other Monthly Expenses (such as clothing, taxes, tuition, school, supplies, etc.)	\$ _____
Total Monthly Expenses:	\$ _____

Financial Contact

Please designate the person (spouse, family member or close friend) who will handle your financial affairs in the event of your absence, such as in the case of hospitalization.

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Phone: Hm/Wk (_____) _____ Cell (_____) _____ E-mail _____

NFT Fundraising Campaign

The success of the NFT fundraising campaign is directly related to the commitment level of volunteers involved. Please provide the names and contact information for those who agree to spearhead the campaign in your honor. The campaign chair and treasurer are required leadership positions and will be trained and guided by NFT staff. **Once the campaign gets underway, please provide a complete list of your campaign volunteers to your NFT Fundraising Consultant.**

Campaign Chair _____ Relation to Patient: _____

Home Address _____ City _____ State _____ Zip _____

Phone: Hm/Wk (____) _____ Cell (____) _____ E-mail _____

Treasurer _____ Relation to Patient: _____
(cannot live in the same household as patient)

Home Address _____ City _____ State _____ Zip _____

Phone: Hm/Wk (____) _____ Cell (____) _____ E-mail _____

Volunteer _____ Relation to Patient: _____

Home Address _____ City _____ State _____ Zip _____

Phone: Hm/Wk (____) _____ Cell (____) _____ E-mail _____

Volunteer _____ Relation to Patient: _____

Home Address _____ City _____ State _____ Zip _____

Phone: Hm/Wk (____) _____ Cell (____) _____ E-mail _____

Patient Agreement

Do you presently have a bank account set up to receive funds on your behalf for your transplant-related medical expenses, or have you partnered with another fundraising organization? ____ Yes ____ No If yes, please explain _____

To ensure the integrity of NFT and its community campaigns, any existing bank accounts for the purposes of fundraising must be closed. No other accounts should be opened. No other fundraising organization should be consulted while partnering with NFT without prior consent of NFT. Funds raised prior to signing with NFT may be sent to NFT without being subject to the NFT's 5% retention fee. Such funds should be received by NFT within 30 days of the date of the signed agreement.

I agree that all funds raised in my honor while partnering with NFT will be sent to NFT to be used for the agreed upon purposes as set forth in NFT's Policies for Assistance. I have received, read and understand NFT's Policies for Assistance.

I give my consent for NFT to (a) receive copies of all my (or my child's) medical information and records (b) receive all information concerning my (or my child's) health insurance coverage and assignment of benefits (c) use my (or my child's) name, photograph and general medical description in media coverage and other awareness or fundraising activities for the purpose of raising funds and to benefit the general purposes of NFT. I affirm that the above information is true and correct.

Printed Name of Transplant Patient

Signature of Transplant Patient *(Parent or legal guardian if patient is under age 18)*

*Please retain a copy of this Agreement before returning to NFT at 5350 Poplar Ave., Suite 430, Memphis, TN 38119
You may also fax the Agreement to 901-684-1128. Please also mail the original. Thank you!*