



## Questionnaire & Agreement

National Foundation for Transplants (NFT) offers financial assistance to transplant patients through fundraising and grant programs. Assistance is provided for the patient's out-of-pocket transplant-related expenses. To be considered for NFT's assistance program, this agreement must be completed in its entirety, signed, and received at the NFT office. For details, refer to NFT Policies for Assistance. A patient photo and a letter from the patient's transplant professional or physician verifying that the patient needs (or has received) a transplant are also required.

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

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### Personal Information

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Patient's Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name as you want it to appear on campaign materials \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail address \_\_\_\_\_

Telephone: Daytime (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; Cell (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Do you have children? \_\_\_ Yes \_\_\_ No; If yes how many \_\_\_\_; Are they living with you? \_\_\_ Yes \_\_\_ No

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### Medical Information

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Type of transplant needed \_\_\_\_\_ Medical Diagnosis \_\_\_\_\_

For organ transplant candidates, are you on the waiting list now? \_\_\_ Yes \_\_\_ No

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

Hospital where transplant will be performed \_\_\_\_\_

Financial Coordinator: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Social Worker's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Transplant Coordinator: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Transplant Physician: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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## Insurance Information

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**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 \$ \_\_\_\_\_

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

Does your health insurance cover:

- Transplant surgery expenses? \_\_\_\_ Yes \_\_\_\_ No or Partial ( \_\_\_\_ %)
- Post-transplant medications? \_\_\_\_ Yes \_\_\_\_ No or Partial ( \_\_\_\_ %) Co-Pay Amounts: \_\_\_\_\_
- Bone marrow donor search? \_\_\_\_ Yes \_\_\_\_ No or Partial ( \_\_\_\_ %)

**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? \$ \_\_\_\_\_

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## Transplant Costs

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**Transplant medical costs are difficult to estimate. Please request that your Financial Coordinator assist you with this section.**

What is the estimated total cost for donor search or procurement? \$ \_\_\_\_\_

What is the estimated total cost for your transplant (hospital and physicians)? \$ \_\_\_\_\_

Is there a deposit required by the hospital? If so, what is the amount? \$ \_\_\_\_\_ Is this a medication reserve? \_\_\_\_

Will you need assistance with travel, food and lodging? \_\_\_\_\_ Distance to your transplant center: \_\_\_\_\_

Describe other anticipated transplant-related expenses \_\_\_\_\_

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What are your estimated out-of-pocket costs for:

- Donor search or procurement \$ \_\_\_\_\_
- Transplant Hospital \$ \_\_\_\_\_
- Monthly post-transplant medications \$ \_\_\_\_\_
- Other (Please explain) \_\_\_\_\_ \$ \_\_\_\_\_
- Monthly pre-transplant medications \$ \_\_\_\_\_
- Transplant Physicians \$ \_\_\_\_\_
- Travel/Food/Lodging, if needed \$ \_\_\_\_\_

**What are your total estimated out-of-pocket transplant-related costs not covered by insurance? \$ \_\_\_\_\_**

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NFT Fundraising Drive

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**The success of the NFT fundraising campaign is directly related to the number of volunteers involved.  
Please provide the names and contact information for those who agree to spearhead the campaign in your honor.**

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Campaign Leadership

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**Campaign Chair** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Campaign Co-Chair (optional)** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Treasurer** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Publicity Coordinator** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

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Fundraising Committee

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**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

**Volunteer Name** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_; Evening (\_\_\_\_) \_\_\_\_\_; E-Mail Address: \_\_\_\_\_

Financial Information

Are you Medicaid Approved? \_\_\_\_\_ Yes \_\_\_\_\_ No; If yes, attach a copy of the front and back of your Medicaid card or other proof. If you are Medicaid approved, you may skip this financial information section.

**NOTE: You must notify NFT of any changes in your Medicaid eligibility status.**

Assistance is based on your financial needs and NFT policy. In order to establish financial need, NFT is required to collect financial information from the patient requesting assistance. Complete the form below as completely as possible.

- If the patient is married, include income and expenses of both the husband and wife.
- If the patient is a dependent, then include all household income and expenses.
- If the patient is not a dependent, but resides with other family members, then only the patient’s income and expenses should be included.

**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)	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
<b>Total Monthly Income:</b>	<b>\$ _____</b>

**Average Monthly Expenses**

<b>Household</b>	
Rent or Mortgage	\$ _____
Food	\$ _____
Utilities	\$ _____
Telephone	\$ _____
Other _____	\$ _____
<b>Transportation</b>	
Auto Payments	\$ _____
Gasoline	\$ _____
Maintenance	\$ _____
<b>Medical (not covered by insurance)</b>	
Doctors’ Fees	\$ _____
Hospital Payments	\$ _____
Applicant’s Medications	\$ _____
Family Medications	\$ _____
<b>Insurance</b>	
Medical	\$ _____
Life	\$ _____
Automobile	\$ _____
Disability	\$ _____
Home	\$ _____
<b>Other Expenses (such as clothing, taxes, tuition, school supplies—please specify)</b>	
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
<b>Total Monthly Expenses:</b>	<b>\$ _____</b>

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Miscellaneous

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Do you have any specific concerns that are not covered on this form that you wish to bring to our attention?

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Who referred you, or how did you learn about NFT? \_\_\_\_\_

Do you presently have an account set up to receive funds on your behalf for your transplant-related medical expenses?

\_\_\_ Yes \_\_\_ No If yes, please explain \_\_\_\_\_

To ensure the integrity of NFT and its community campaigns, any existing fundraising bank accounts or funds to benefit the patient must be closed, and no other accounts may be opened. Your signature below affirms that you agree to abide by this policy. Funds raised prior to signing with NFT can be sent to NFT without being subject to the NFT 5% retention fee. Such funds should be received by NFT within 30 days of the date of the signed agreement.

*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 \_\_\_\_\_ Daytime phone (\_\_\_\_) \_\_\_\_\_

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Patient Agreement

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**I affirm that the above information is true and correct. I have received and read NFT's Policies for Assistance and agree to abide by them.** I also 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.

NFT is a national organization that 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

\_\_\_\_\_  
Printed Name of Transplant Patient

\_\_\_\_\_  
Signature of Transplant Patient  
(Parent or Legal Guardian if patient is under 18 years of age)

\_\_\_\_\_  
Date

*Please retain a copy of this agreement before returning it to NFT at 5350 Poplar Ave., Suite 430, Memphis, TN 38119.*