2023 RECIPIENT APPLICATION WORKSHEET

LIVING ORGAN DONATION REIMBURSEMENT PROGRAM

Instructions: NLDAC helps living organ donors with their travel expenses, lost wages, and dependent care expenses if their recipient cannot afford to do so. To apply, the donor and their recipient must complete these application worksheets, attach a copy of a document that verifies their household income, and send their application to a transplant professional (social worker, nurse coordinator, etc.), who will submit the application to NLDAC. Do not send your application materials to NLDAC. NLDAC can only accept applications from transplant centers. Applications must be approved before surgery, and NLDAC cannot reimburse expenses incurred before the application is approved. Application review takes 15 business days. For more information, call NLDAC at (888) 870-5002. If this application is not approved, the recipient can provide financial assistance to the donor. While the National Organ Transplant Act (NOTA) prohibits the buying and selling of organs, it allows reasonable payments associated with the expenses of travel, housing, lost wages, and dependent care incurred by the donor of a human organ.

First name	Last name	Date of birth	Social Security number

Street address		
City	State	Zip code

Sex	Race	Ethnicity
☐ Male ☐ Female	☐ American Indian or Alaska native ☐ Asian ☐ Black ☐ Native Hawaiian or other Pacific Islander ☐ White	☐ Hispanic ☐ Not Hispanic

Are you a U.S. citizen or lawfully present resident? Yes ☐ No ☐

Have you signed the Attestation Form? (*See page 2)* Yes ☐ No ☐

Are you currently on dialysis? Yes ☐ No ☐

Does your health insurance provide a travel benefit for your living donor? Yes ☐ No ☐

If yes, what benefits are covered by your insurance (e.g. hotel, transportation, meals?)

If your health insurance provider is UnitedHealthcare, look at the bottom right of your insurance card. Does it say, "Underwritten by UnitedHealthcare?"

If yes, list the policy number: , member ID: and policy holder's name to verify coverage.

If it says, "Administered by UnitedHealthcare Services, Inc.", is one of the following listed below "Group Name": UnitedHealth Group, Inc.; Optum Care, Inc.; Optum360 Services, Inc.?

INCOME INFORMATION: ***Combine the incomes of all members of your household. The transplant professional who files your application will confirm and record household income based on the document(s) you provide.***

Yearly household income	$	Persons in household	#

Select the income document used to verify your household income and give a copy to your transplant professional.

- ☐ Federal income tax return - most recent year **(use adjusted gross income)**
- ☐ Pay stubs **(use gross income)**
- ☐ W2 **(use gross income)**
- ☐ Government assistance program (HUD, WIC, SNAP)
- ☐ Medicaid eligibility
- ☐ Social Security statement
- ☐ Other document - (i.e. disability statement, etc.)

Recipient Attestation Form

Transplant professionals: please retain this form in the recipient candidate's medical record.

Instructions: Write your name in the blank near the top, read the statements and check all the boxes (except the last one, unless it applies to you), and sign your name at the bottom.

I, _____, as a transplant candidate, have truthfully and completely provided all the information requested in the application for reimbursement of travel and subsistence expenses and/or lost wages toward living organ donation.

☐ The transplant center personnel have informed me of what constitutes "valuable consideration" and to the best of my understanding, I am in full compliance with Section 301 of NOTA (42 U.S.C. §274e), which stipulates, in part, that it shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

☐ My decision to undergo live organ transplantation was not motivated by the exchange of any valuable consideration.

☐ I do not have any other information indicating that valuable consideration is being exchanged in connection with this donation procedure.

☐ I understand that NLDAC, under Federal law, cannot provide reimbursement to any living organ donor for travel and other qualifying expenses if the donor can receive reimbursement for those expenses from any of the following sources: (1) Any state compensation program, an insurance policy, or a Federal or State health benefits program; (2) an entity that provides health services on a prepaid basis; or (3) the recipient of the organ.

☐ I give permission for the transplant center to share my information with the National Living Donor Assistance Center.

☐ (for UnitedHealthcare insured transplant candidates only) I give permission to NLDAC to provide the information in the application to other entities, including my health insurer, for review and potential reimbursement for travel and other qualifying expenses for my donor. The health insurer will only use or disclose this information in accordance with applicable law.

In signing this form, I declare, under penalty of perjury under the Federal and State laws, that all the information I have provided is true, correct and complete. I further understand that Federal and State law may provide for penalties of fine and/or imprisonment or denial of the requested travel and subsistence reimbursement assistance if I do not tell the truth when applying for assistance under the live donor reimbursement program or if I conceal or fail to disclose facts regarding the information supplied in the application process.

Recipient's signature: _____ Date: _____

Transplant center application filer's signature: _____ Date: _____

FINANCIAL HARDSHIP WAIVER WORKSHEET – 2023

IMPORTANT: ***Skip this page if your household income is equal to or below the NLDAC eligibility guidelines.***

NLDAC Eligibility Guidelines 350% HHS Federal Poverty Guidelines (FPG) 2023			
Household size	**48 Contiguous states and D.C.**	**Alaska**	**Hawaii**
1	$51,030	$63,735	$58,695
2	$69,020	$86,240	$79,380
3	$87,010	$108,745	$100,065
4	$105,000	$131,250	$120,750
5	$122,990	$153,755	$141,435
6	$140,980	$176,260	$162,120
7	$158,970	$198,765	$182,805
8	$176,960	$221,270	$203,490

Recipients: According to federal law, NLDAC cannot pay for a donor's travel expenses, lost wages, or dependent care expenses if the recipient can pay those costs. If your household income is above the NLDAC guidelines but you cannot support the donor, you can request NLDAC reconsider your ability to pay by completing this worksheet, which is a financial hardship waiver request. The financial hardship waiver process requires evaluation by the transplant professional, NLDAC and the Health Resources and Services Administration using fact-specific analysis of information captured in the form below. Your allowable out-of-pocket expenses must bring your income within the income guidelines for the application to be approved. For example, if your income is $5,000 above the NLDAC eligibility guidelines, you will need to demonstrate $5,000 in allowable annual expenses.

Please list monthly or one-time out-of-pocket expenses for ***your entire household****. NLDAC will calculate annual expenses based on the information provided in the worksheet.* ***Regular living expenses (like rent, utilities, etc.) should not be included.*** *If you have questions, call NLDAC toll free at (888) 870-5002.*

First name:	Last name:
Phone:	(*NLDAC staff may call you to clarify information on this worksheet.*)

1.	$	Monthly out-of-pocket **medical insurance** premiums (medical, dental, vision)
2.	$	Monthly out-of-pocket **pharmacy** co-pays **before transplant**
3.	$	Monthly out-of-pocket **pharmacy** co-pays **after transplant** *(Estimated by transplant professional)*
4.	$	Monthly out-of-pocket **physician** co-pays
5.	$	Monthly out-of-pocket **lab or other medical** co-pays **not listed above**
6.	$	Total hospital/medical bills owed **not covered by insurance** *(not monthly)*
7.	$	Loss of income due to surgery (excluding paid time off/disability pay) - describe in ***Comments**
8.	*# miles*	Monthly round trip **mileage** for medical appointments (pre-transplant)
9.		How will you travel to the transplant center for your surgery? Air ☐ Car ☐ Bus ☐ Train ☐
10.	*# miles*	If driving, how many **miles** round trip to the transplant center?
11.	*yes/no*	Will you need to stay in a hotel near the transplant center after your transplant surgery?
12.	*# nights*	If you will stay in a hotel, how many nights will you stay?
13.	*# trips*	In the first 3 months after your transplant, how many trips (estimate) will you make to the hospital?
14.	$	Monthly dependent care for family member not living in the household (ex. child support) - describe in ***Comments**
15.	$	Other expenses - describe in ***Comments**

If loss of income, monthly dependent care for a family member not living in household, or other allowable expenses are noted above, please describe those expenses here. You may attach an additional page if desired.

***Comments:**