



## Transplant Related Expenses & Insurance Grants

The following list is reasonable transplant related expenses that the organization will fund:

- Prescription drugs necessitated by the transplant for the patient.
- Medical bills and/or co-pays related to the transplant patient.
- Dental assistance for transplant candidate.

**These items are not considered transplant expenses and will not be reimbursed:**

- |  |                                    |
|--|------------------------------------|
| * Entertainment items                                    | * Postage                          |
| * Clothing   | * Auto repairs                     |
| * Personal Products                                      | * Computers                        |
| * Rehab therapy not administered by a licensed therapist | * Loss of income                   |
|  | * Expenses unrelated to transplant |

*Please note this is not a completed list of expenses.*

### Guidelines for funding:

In order for your application to be considered, the following items need to accompany your application:

- Proof of Michigan residency during the last twelve months prior to this application date. Proof of residency can be a utility bill, bank statement or a driver's license with the expiration date.
- Proof of Income ó You may either enclose a copy of the most recent State Income Tax or a most recent check stub or social security income statement.
- Proof of Health Insurance if applicable ó A copy of your Medicare, Medicaid or private insurance card. If you don't have health insurance, please note that you have no insurance.
- Receipts for all medical related expenses that you are seeking reimbursement for including documentation: Examples: Copy of medication prescribed and costs and copy of medical bills and costs.

**Date of Application:** \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

**Please Print Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_



# Second Chance at Life

---

## Client Information Section:

---

First Name	Middle	Last Name	
Street Address		Apt./Suite Number	
City	State	Zip Code	County
Home Phone	Cell Phone	E-Mail	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married*	<input type="checkbox"/> Single

\* If married, please provide your spouse's name \_\_\_\_\_

---

Date of Birth	Age
---------------	-----

---

Number in Household	Number of Children (living in household)
---------------------	--

## Demographical Information:

---

Transplant Center	Date of Transplant	Organ
-------------------	--------------------	-------

### Current Source of Income (Please check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Full-Time employment | <input type="checkbox"/> with benefits | <input type="checkbox"/> Social Security Disability (SSDI) |
| <input type="checkbox"/> Part-Time employment | <input type="checkbox"/> with benefits | <input type="checkbox"/> Supplemental Security Income      |
| <input type="checkbox"/> Other _____          |  |  |

**Current Healthcare Coverage – Please list what type of insurance you have, if none, state none.**

---

### Check all that apply:

- |                                    |                                    |                                       |
|------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Recipient | <input type="checkbox"/> Candidate | <input type="checkbox"/> Living donor |
|------------------------------------|------------------------------------|---------------------------------------|

# Financial Assistance Application

**Assets** Do not leave any fields blank in this section

Checking Account \$ \_\_\_\_\_  
Savings Account \$ \_\_\_\_\_  
Retirement \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

## Monthly Household Income

Wages (net) \_\_\_\_\_  
Social Security \_\_\_\_\_  
Pension \_\_\_\_\_  
Spouse's Income \_\_\_\_\_  
Retirement Income \_\_\_\_\_  
Dividends if applicable \_\_\_\_\_  
Other (specify) \_\_\_\_\_  
\_\_\_\_\_

## Monthly Household Expenses

Rent/Mortgage \_\_\_\_\_  
Food \_\_\_\_\_  
Utilities Total \_\_\_\_\_  
Auto Payment/Gas \_\_\_\_\_  
Insurance – Medical \_\_\_\_\_  
Insurance – Life \_\_\_\_\_  
Insurance – Auto \_\_\_\_\_  
Charge Accounts \_\_\_\_\_  
Other \_\_\_\_\_

**Total Monthly Income:** \_\_\_\_\_ **Total Monthly Expenses** \_\_\_\_\_

I authorize information released between Second Chance at Life and my transplant Center or other related parties to verify information related to this request. I agree to be added to Second Chance at Life for future mailings.

\_\_\_\_\_  
Applicants Signature Date

If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

