



Second Chance at Life

Transplant Related Expenses & Insurance Grants

The following list is reasonable transplant related expenses that the organization will fund. Which one(s) are you applying for? Please check all that apply. Grants are issued at a maximum of \$1,000.00 per person for a lifetime.

- Prescription drugs necessitated by the transplant for the patient.
- Medical bills and/or co-pays related to the transplant patient.
- Dental assistance for pre-transplant candidate.
- A one-time grant (maximum \$1,000.00) to assist with medical premiums as a bridge while patients are recovering from transplant.

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 and the charity does not reimburse the individual.*

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. Must be 18 or older.
- Proof of Income – 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 – A copy of your Medicare, Medicaid or private insurance card. If you don't have health insurance, please note that you have no insurance.
- Invoices/quotes for all medical related expenses that you are seeking the charity to pay the company/creditor directly: Examples: Copy of medication prescribed and costs, copy of medical invoice or quote from dental office.

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	
Date of Birth	Age		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married*	<input type="checkbox"/> Single
* If married, please provide your spouse's name _____			
Number in Household	Number of Children (living in household)		

Demographical Information:

Transplant Center	Date of Transplant	Organ
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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
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How did you hear about Second Chance at Life? _____

Do not leave any field blank

Financial Assistance Application

Assets Do not leave any field's blank in this section

Checking Account \$ _____
Savings Account \$ _____
Retirement \$ _____
Other \$ _____

Monthly Household Income
*(please read below)

Monthly Household Expenses
*(please read below)

Wages (net)		Rent/Mortgage	
Social Security		Food	
Pension		Utilities Total	
Spouse's Income		Auto Payment/Gas	
Retirement Income		Insurance – Medical	
Dividends if applicable		Insurance – Life	
Other (specify)		Insurance – Auto	
		Charge Accounts	
		Other (specify)	

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: _____

*** Income:** Total amount for wages or salary, self-employment, pensions, rental income, income from lawsuit, unemployment income, Social Security, Social Security Disability Income, child support, public assistance and any income from working spouse, children, parents, siblings, grandparents, renters or any other person(s) related or non-related residing in your household.

*** Expenses:** General household expenses per month-rent/mortgage, food, utilities, phone, credit card(s) monthly amount paid (not balances owed).

Patient's Name: _____

Check(s) Payable to: (List name of payee and attached supporting documents)

1. _____ Amount _____

2. _____ Amount _____

3. _____ Amount _____

4. _____ Amount _____

Total Amount Requested: _____

You may attach on a separate sheet a list of additional items to be paid and amount if needed.

Social Worker's Statement (must be completed):

(Please document fully the background information creating the need and your recommendations)

Requesting Social Worker: _____

Transplant Center: _____

Contact Information: _____

- *All checks will be paid directly to the companies/creditors listed above.*
- *Please remember to attach your supporting information*
- *Please verify financial information is correct*
- *Please mail applications to 32591 Judy Drive, Westland, Michigan 48185 or fax to (734) 293-2640, Attn: Second Chance at Life*