



APPLICATION FOR ASSISTANCE FOR ADULT PATIENTS		
PATIENT INFORMATION		
Name:		E-mail:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
EMPLOYMENT INFORMATION		
Current Employer:		Position:
Address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
PATIENT'S DEMOGRAPHIC INFORMATION		
Marital Status: <i>(Please circle)</i> Married Single Widowed Separated Divorced		County of Residence:
Race: <i>(Please circle)</i> African-American Asian Caucasian Hispanic Other _____		Age:
Number in household:	Gender: <i>(Please circle)</i> Male Female	Type of Transplant:
SPOUSE INFORMATION		
Name:		E-mail:
Date of birth:	SSN:	Phone:
SPOUSE EMPLOYMENT INFORMATION		
Current Employer:		Position:
Address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
TRANSPLANT CENTER INFORMATION		
Name:		
Address:		
City:	State:	ZIP Code:
Physician:		Surgeon:
Coordinator:		Social Worker:
Phone:		Date of initial consult:
Date listed for transplant:		Date of transplant:

FINANCIAL AFFIDAVIT		
MONTHLY HOUSEHOLD INCOME		
Salary/Wages:	SSI/SSDI:	Other Disability Income:
Interest & Dividends:	Rental Income:	Unemployment Income:
Retirement/Pension:	Other Income:	TOTAL:
MONTHLY HOUSEHOLD EXPENSES		
Rent/Mortgage:	Food:	Assoc. Dues:
Electricity:	Water/Sewer/Garbage:	Gas:
Phone:	Vehicle Payment:	Gasoline:
Medical Bills:	Dental Bills:	Medication:
Medical Insurance:	Life Insurance:	Auto Insurance:
Other Insurance:	Credit Cards:	Loans:
Childcare:	Other Expenses:	TOTAL:
ASSETS		
Checking Accts:	Savings Accts:	Automobiles:
Real Estate:	Other Investments:	TOTAL:
LIABILITIES		
Mortgage Balance:	Loan Balance:	Credit Card Balance:
Medical Liabilities:	Other Liabilities:	TOTAL:

NOTE: Please request a letter from your transplant surgeon, nurse coordinator or social worker recommending you for financial assistance. The letter must include a brief description of circumstances, diagnosis and prognosis and may be mailed, e-mailed or faxed.

Please initial each statement and sign below.

_____I authorize information released between the Nielsen Organ Transplant Foundation, TRIO of Northeast Florida and my transplant center or other related parties to verify information related to this request.

_____I certify that the information contained in this application is accurate and true.

_____I authorize the addition of my contact information to the Nielsen Organ Transplant Foundation's and TRIO of Northeast Florida's database for future mailings, such as notification of events and volunteer opportunities. (optional)

Signature of Applicant

Date

Signature of Co-Applicant

Date



SPECIFIC REQUEST FORM FOR RICK PRACHER MEDICATION FUND		
PATIENT INFORMATION		
Name:		E-mail:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
REQUEST #1		
Payable to:		Amount:
Vendor address:		Date Due:
City:	State:	ZIP Code:
Memo:		Account #:
Delivery: <i>(Please circle)</i> Mail to Vendor Mail to Applicant Call Applicant for pick-up		Description:
REQUEST #2		
Payable to:		Amount:
Vendor address:		Date Due:
City:	State:	ZIP Code:
Memo:		Account #:
Delivery: <i>(Please circle)</i> Mail to Vendor Mail to Applicant Call Applicant for pick-up		Description:

NOTE: Requests will not be approved without documentation. Please provide proof of expense, such as a bill, statement, receipt or invoice. If a payment stub is available, please provide it as it will ensure that your account is credited correctly.

APPLICANT: I certify that the information provided on this form is accurate and correct.

Signature of Applicant

Date

SOCIAL WORKER: I have evaluated this applicant's request and to the best of my knowledge agree that this (these) request(s) are valid and appropriate requests for financial assistance.

Signature of Social Worker

Date