**REIMBURSEMENT OF LIVING EXPENSES/WAGES LOST**

**THROUGH LIVING ORGAN DONATION**

**Donor Candidate Application Form**

**Instructions:** Thank you for applying to the Heal With Love Foundation (HWLF). Please complete this worksheet and return it to HWLF at **P.O. Box 91, Brookfield, IL 60513 PRIOR** to your surgery date. You **MUST** provide documentation of your household income. You must include your most recent pay stubs **AND** Federal Income Tax return page 1 and 2.

Please feel free to email HWLF at healwithlove@comcast.net if you have questions or need more information.

**STEP 1: DONOR INFORMATION**

First Name       Middle Name       Last Name

DOB       SSN       [ ] Male [ ] Female

 Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Significant Other

Education: [ ] Grade School [ ] High School/GED [ ] Post HS/Tech or Trade [ ] Some College [ ] College Grad – 4 year

 [ ] Post College/Professional

Employment Status: [ ] Full Time [ ] Part Time [ ]  On Disability Leave [ ] Retired [ ] Homemaker/Caretaker [ ] Student

[ ] Unemployed

Are you a U.S. citizen or lawfully admitted resident? Yes [ ]  No [ ]

Have you signed a HIPAA release and authorization form? Yes [ ]  No [ ]

Have you signed a HWLF Donor Attestation Form? Yes [ ]  No [ ]

*(Your transplant professional can help you with this form.)*

**RELATIONSHIP TO TRANSPLANT CANDIDATE**

The donor is the       of the Recipient. (*Choose one: Father, Mother, Sister, Brother, Son, Daughter, Spouse, Other)*

If other, please specify:

**Type of Relationship:** Blood Related [ ]  Non-Blood Related [ ]  Unrelated [ ]

**ADDRESS**

Street Address      City

State      Zip

Phone#      Alternate Phone #

E-mail

**Send reimbursement to address of primary residence?** Yes[ ]  No[ ]  If no, complete the following:

Street Address      City      State       Zip

**STEP 2: DONOR INCOME VERIFICATION**

Total monthly household income $

Number of Dependants claimed on your income tax form:

Please specify:

Name Age Relationship

If you will lose income due to living donation, please estimate amount $     .

**Document(s) used to verify household income**:

[ ]  Federal Income Tax Return (most recent year, first page only) **Required**

[ ]  Government Assistance (HUD, Section 8 Housing)

[ ]  Government Assistance (WIC, Food Stamps Program)

[ ]  Medicaid

[ ]  W2

[ ]  Pay Stubs (Two most recent Pay Stubs are **Required**)

[ ]  Other: Specify:

 **Donors must be currently employed to be eligible for wage reimbursement**. Please provide employer information. We will be contacting your employer for verification.

Company Name:

Address:

Telephone:

Contact Person: Position/Title:

**RECIPIENT INCOME VERIFICATION**

Total monthly household income $

Number of people in your household

**Document(s) used to verify household income**:

[ ]  Federal Income Tax Return (most recent year)

[ ]  Government Assistance (HUD, Section 8 Housing)

[ ]  Government Assistance (WIC, Food Stamps Program)

[ ]  Medicaid

[ ]  W2

[ ]  Pay Stubs (Two most recent Pay Stubs are **Required**)

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name:

Address:

Telephone:

Contact Person:       Position/Title:

**STEP 3: RESEARCH QUESTIONS**

How you answer these questions is not going to affect your eligibility to receive the lost income/expense reimbursement. Your answers may help HWLF demonstrate the need to raise funds through grants and may help us learn how to tailor assistance to donors in the future-Thank you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| The HWLF program will make it possible for me to donate an organ | True | [ ]  | False | [ ]  |
| The HWLF program will help my stress and give me less worry  | True | [ ]  | False | [ ]  |

**STEP 4: TRANSPLANT CENTER INFORMATION**

Please provide the name and address of the transplant center as well as the contact information of your transplant coordinator.

Transplant Center Name:

Transplant Center Address:

Transplant Coordinator Name:

Address:

Telephone:       FAX:

E-Mail:

Expected Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Donor Candidate Attestation Form**

|  |
| --- |
| **Heal With Love Foundation****Donor Candidate Attestation****Retain this form in patient medical record** |
| I, Click here to enter text., as a live organ donor candidate have truthfully and completely provided all the information requested in the application for reimbursement of travel and subsistence 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 donation 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 Heal With Love Foundation, under Federal law, cannot provide reimbursement to any living organ donor for 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.  |
| 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 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. |
| Signed:   |  |  |
| Name:   |       | Date  |       |  |
|   | (Typed name constitutes signature when form is submitted electronically.) |  |  |  |
|  |

**HIPAA PRIVACY AUTHORIZATION FORM**

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act,

45 C.F.R. Parts 160 and 164)

**1. Authorization**

 I authorize       (healthcare provider) to use and disclose the protected health information described below to the Heal With Love Foundation.

**2.** **Effective Period**

 This authorization for release of information covers the period of healthcare from       (date) until confirmation of the completion of the kidney donation process is received from the transplant center, at which time this authorization expires.

**3. Extent of Authorization**

 I authorize release of my health record specifically relating to living kidney donation. This medical information may be used by the Heal With Love Foundation to determine my eligibility to receive grant funds from the Heal With Love Foundation.

**4. Right to Revoke**

 I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

DATE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

(Typed name constitutes signature when form is submitted electronically.)

Once completed, please print this form and mail it along with any supporting documents to:

 **Heal With Love Foundation**

**P.O. Box 91, Brookfield, IL 60513**

Or by e-mail to: healwithlove@comcast.net

Please put Application for Assistance in the subject line and attach scanned copies of your supporting documents.

**ELIGIBILITY SCREENING TOOL**

Program eligibility is based on recipient and donor household income. The donor’s eligibility to receive funding is based on 300% of the HHS Federal Poverty Guidelines (FPG). Income verification documents must be submitted by the donor and recipient households. Documents used to verify income include most recent year tax return, pay stubs, documentation of Medicaid, HUD Section 8, WIC, SSDI, etc.

**300% HHS FEDERAL POVERTY GUIDELINES (FPG) 2019**

|  |  |  |  |
| --- | --- | --- | --- |
| **Persons in Family or Household** | **48 Contiguous States and D.C.** | **Alaska** | **Hawaii** |
| **1** | **$37,470** | **$46,800** | **$43,140** |
| **2** | **$50,730** | **$63,390** | **$58,380** |
| **3** | **$63,990** | **$79,980** | **$73,620** |
| **4** | **$77,250** | **$96,570** | **$88,860** |
| **5** | **$90,510** | **$113,160** | **$104,100** |
| **6** | **$103,770** | **$129,750** | **$119,340** |
| **7** | **$117,030** | **$146,340** | **$134,580** |
| **8** | **$130,290** | **$162,930** | **$149,820** |