4200 E. North St•22 Centre East•Greenville•SC•29615
Tel: 864-609-5270•Fax: 864-609-5387•Toll free: 877-277-4866•www.donatelifesc.org

Patient Funding Guidelines

Purpose: Donate Life SC is a charitable provider of temporary financial assistance to organ and tissue transplant recipients of South Carolina. The fund is designed to help pay for medical and other related expenses that are of an emergency or non-insured nature. There is a limited amount of financial assistance that will be provided per person per year. Since funds are distributed from charitable donations, assistance will be provided as funds are available. Specific eligibility criteria apply.

This is not an entitlement program. Once an application is received, an evaluation process determines whether assistance will or will not be provided.

Eligibility: applicant must meet all of the following criteria:

- ☐ Must be a citizen and resident of the state of South Carolina.
- ☐ Must be post organ/tissue transplant, on the **active** waiting list for a transplant, or in the **approved** transplant evaluation process.
- ☐ Must have a medical or related need for financial assistance which is of an emergency or non-insured nature.
- ☐ Must complete the Donate Life SC's Patient Assistance application form.
- ☐ The applicant must have a total household income of less than $30,000 for a family of four. Extenuating circumstances should be listed; i.e., number of family members, costs of care, etc.
- ☐ The application for assistance is completed with and submitted by the transplant social worker/financial coordinator.
- ☐ Other documentation is to be submitted if requested by Donate Life South Carolina.
- ☐ The application must include proof of household income. This may include tax statements, pay stubs, Social Security statements and other documents.

Funding Protocol: Any distribution of funds will be made directly to a service provider, such as but not limited to, such entities as a pharmacy, landlord, or utility company. A copy of the bill or formal cost estimate must be submitted with the application. Payments are made for specific quantities.

Application Submission: Completed applications should be faxed to Adriane Gonick, Office Program Manager at (864) 609-5387 or mailed to the Donate Life SC, 4200 E. North Street, 22 Centre East, Greenville, SC 29615.

These guidelines are subject to change without notice and can be amended by the Donate Life SC Board of Directors. Incomplete applications will not be processed. The Donate Life SC reserves the right to deny applications. Funds will be distributed on a nondiscriminatory basis without regard for age, gender, race, religion or ethnicity.

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Patient Assistance Application

Patient's Name Last First Middle

Address

City State Zip County

Date of Birth Social Security Number

Telephone Marital Status

Spouse's Name(or Parent or Guardian) Number of Dependents and Ages of Each

Most Recent Employer

Address

Most Recent Date of Employment Telephone #

Insurance: Does the patient have: Medicare ? **Yes** **No**
Medicaid ? **Yes** **No**
Insurance? **Yes** **No** If yes provide the following**:**

Insurance Company Name: _____

Address: _____

Policy Number: _____

Employer's Name: _____

Employer's Address: _____

Spouse's Employer's Name: _____

Spouse's Employer's Address: _____

Monthly Take-Home Pay $ _____
Disability Insurance $ _____
Spouse's Take-Home Pay $ _____
Other Household Members' Pay $ _____
Social Security $ _____

Retirement	$ _____
Medicaid or SSI	$ _____
Other Government Benefits	$ _____
TOTAL MONTHLY INCOME	$ _____

Patient's Name:

_____

(Please print or type)

ASSETS:

Checking Accounts:	$ _____	
Bank Accounts:	$ _____	(Itemize separately)
Savings Accounts:	$ _____	
Home Assessed Value:	$ _____	
Stocks and Bonds	$ _____	(Itemize separately)
Auto Make: _____ Model: _____	$ _____	(List all vehicles)
Other Real Estate:	$ _____	

LIABILITIES:

Loan Institutions and Debts		$ _____	
(Attach documentation).		$ _____	
Monthly Medical Expense:	Doctors' Fees	$ _____	
	Hospital Fees	$ _____	
	Medications	$ _____	(Itemize separately)
	Family Medications	$ _____	
	Food	$ _____	
	Rent or Mortgage	$ _____	
	Telephone	$ _____	
	Electricity	$ _____	
	Water/Sewer	$ _____	
	Heating	$ _____	
	Taxes	$ _____	
	Transportation	$ _____	
	Auto Payments	$ _____	
	Gasoline	$ _____	
Insurance:	Medical Insurance	$ _____	
	Auto Insurance	$ _____	
	Life Insurance	$ _____	
Charge Accounts/ Credit Cards:		$ _____	
Loan Payments:		$ _____	
Other:		$ _____	
Total Monthly Expenses:		$ _____	

Specific Item(s) Needed: Please provide third party payment information (business name, mailing address, and telephone number).

_____

_____

_____
_____
_____
_____

(If this is a medication, please provide name, dose, and frequency.)

Estimated Cost: $ _____

Name of transplant hospital where patient is listed or being evaluated :
_____

Patient's Name: _____
(Please print or type)

The applicant agrees that any financial assistance granted to pay for immunosuppressant medications will be paid directly to the pharmacy. Please have your pharmacy contact us directly. If satisfactory arrangements cannot be made, other arrangements will be made by Donate Life South Carolina.

In submitting this application, the patient, parent or guardian guarantees its accuracy and truth and can be relied upon in considering assistance to the applicant whose signature is listed below. Any misrepresentation will constitute fraud and make the applicant ineligible for assistance.

_____ _____

Signature (Applicant, parent, or guardian) Date

_____ _____

Witness's Signature Date

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Release Form:

Please read carefully before signing

The undersigned authorizes any physician or other provider of health services or financial institution to release to the Donate Life South Carolina (DLSC) and its agents, upon request, **any** information including medical records, financial records, bank statements, real estate holding, tax records of any individual, parents, spouse or guardian whenever such information is considered necessary for the processing of the financial assistance in fulfilling obligations imposed by the Trust Fund by state or federal statutes

I fully understand and agree (1) that the Donate Life South Carolina (DLSC) has the right to accept or reject the request for financial aid as applied for in this application, (2) the DLSC will determine the effective date of such financial aid, (3) that no assistance will be provided until all forms and tax returns are received by the DLSC, (4) if assistance is approved it will depend upon available funds of the DLSC and (5) will be provided as funds become available by donations of the citizens of South Carolina.

It is further understood and agreed that the Donate Life South Carolina (DLSC) may deny assistance or discontinue any coverage if it is determined that any information was misrepresented on the application form.

The undersigned hereby represents that the information on this application and any other information furnished by the undersigned is complete, true and correctly recorded.

I have read and understood each and every part of this application for financial assistance from Donate Life South Carolina.

Patient Name: _____

Signature: _____ Date: _____

Witness Name: _____

Signature: _____ Date: _____

Please return to:
Donate Life South Carolina
4200 East North Street, 22 Centre East
Greenville, SC 29615
Fax: (864) 609-5387
Phone: (864) 609-5270 or toll free 877-277-4866

Social Worker's OR Transplant Coordinator's Statement

Patient's Name: _____
(Please print or type)

Is the patient receiving assistance from any pharmaceutical company? Yes ☐ No ☐

Please provide names, addresses, and telephone numbers of companies and amounts of support:

Name Address Telephone Number Fax Number

_____
_____
_____
_____

Please provide your comments, recommendations, and any history regarding this patient's need for financial assistance. Point out any extenuating circumstances and costs associated with this patient's treatment, such as transportation, away-from-home living expenses, home medical supplies, and costs of medicines, etc. (Use additional page if necessary.)

_____
_____
_____
_____
_____

Specifically identify the request that is being made and the amount requested

_____
_____
_____
_____

Diagnosis:

_____

_____

Has this patient received a transplanted organ? Yes ☐ No ☐

If yes, when was the patient transplanted? Month _____ Day _____ Year _____

Is the patient compliant with medication regimen? Yes ☐ No ☐

Social Worker OR Transplant Coordinator Statement (cont'd)
Patient's Name: _____
(Please print or type)

Are there any extenuating circumstances we should consider in granting financial assistance?

_____

_____

In your opinion, is financial assistance required? Yes ☐ No ☐

Any comments?

_____

_____

Social Worker's or Transplant Coordinator's Name:

_____

Signature:

_____

Physician's Name:

_____

Facility Name and Address :

_____

_____

_____

Date: _____

Telephone # (_____)_____

Fax # (____) _____

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Patient Feedback Form

We are interested in receiving feedback so we can report first-hand the impact of our organization in the lives of patients who have benefited from our services. Feedback can be anonymous.
Comments: _____

_____

_____

_____

_____

_____

_____

(use back of sheet if more space is needed)

Tell us about yourself (optional)

Name: _____

Address: _____

_____

Phone#: _____

email: _____

My signature indicates I give permission to use the information for promotional purposes. Can use:
☐ **comments only or** ☐ **comments and my name**
Signature: _____

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05/2007