2024 DONOR APPLICATION WORKSHEET

LIVING ORGAN DONATION REIMBURSEMENT PROGRAM

Instructions: NLDAC helps eligible living organ donors with their travel expenses, lost wages, and dependent care expenses. To apply, the donor and their recipient must complete these application worksheets, attach a copy of a document that verifies their household income, and send their application to a transplant professional (social worker, nurse coordinator, etc.), who will submit the application to NLDAC. Donors who are applying for reimbursement of lost wages and/or dependent care must also submit a W-9 (lost wages and dependent care) and two pay stubs (lost wages only), in addition to their household income document. Do not send your application materials to NLDAC. NLDAC can only accept applications from transplant centers. Applications must be approved before surgery, and NLDAC cannot reimburse expenses incurred before the application is approved. Application review takes 15 business days. For more information, call NLDAC at (888) 870-5002.

What type(s) of assistance would you like from NLDAC?

☐ Reimbursement of travel expenses ☐ Reimbursement of lost wages ☐ Reimbursement of dependent care expenses

First name	Last name	Date of birth	Social Security number

Important: Full name must match the name on your Social Security card

Sex	Race	Ethnicity	Marital status	Education
☐ Male ☐ Female	☐ American Indian or Alaska native ☐ Asian ☐ Black ☐ Native Hawaiian or other Pacific Islander ☐ White	☐ Hispanic ☐ Not Hispanic	☐ Married ☐ Single ☐ Divorced/separated ☐ Widowed	☐ Grade school ☐ High school/GED ☐ Post HS/tech or trade ☐ Some college ☐ 4-year college ☐ Post college/professional

Employment status		Organ	Please answer:	
☐ Employed full-time	☐ Homemaker/caretaker	☐ Kidney	Are you a U.S. citizen or lawfully present resident?	Yes ☐ No ☐
☐ Employed part-time	☐ Student	☐ Liver	Have you signed the NLDAC Attestation Form? (see page 5)	Yes ☐ No ☐
☐ On disability leave	☐ Unemployed	☐ Lung	The NLDAC Program will make it possible for me to be an organ donor.	Yes ☐ No ☐
☐ Retired		☐ Uterus	Are you self-employed?	Yes ☐ No ☐

Relationship to transplant candidate

I am the _____ of the recipient. ☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Son ☐ Daughter ☐ Spouse ☐ Other

If *other*, please specify:

TYPE OF RELATIONSHIP: ☐ Blood related ☐ Non-blood related (by marriage, in-law, etc.) ☐ Unrelated

Address of primary residence ☐ **Check if donor and recipient live at the same address.**

Street:	City:	State:	Zip:
Location: ☐ Urban ☐ Suburban ☐ Rural			
Cell:	Alt. phone:	Email address:	

If application is approved, we will send approval letter by email

Send reimbursement to address of primary residence? Yes ☐ No ☐ **If no, provide alternative address:**

Street:	City:	State:	Zip:

HOUSEHOLD INCOME INFORMATION: Combine the incomes of all members of your household. The transplant professional who files your application will confirm and record household income based on the document(s) you provide.

Yearly household income: $ **Persons in household:** #

Select the income document used to verify your household income and give a copy to your transplant professional.

☐ Federal income tax return - most recent year **(use adjusted gross income)**
☐ Pay stubs **(use gross income)**
☐ W2 **(use gross income)**
☐ Government assistance program (HUD, WIC, SNAP)
☐ Medicaid eligibility
☐ Social Security benefits statement
☐ Other document - (i.e. disability statement, etc.)

REQUEST FOR REIMBURSEMENT OF LOST WAGES (optional)

Instructions: To apply for reimbursement of your lost wages, follow steps 1, 2, and 3 below. This section is optional, and you can skip it if you would only like help with travel expenses and/or dependent care. NLDAC will use your pay stubs or tax forms to calculate your wage reimbursement. NLDAC can only reimburse documented income. Call (888) 870-5002 if you have any questions or need help identifying the correct income document.

Step 1: Complete this page
Step 2: Complete and sign IRS Form W-9
Step 3: Attach your income document
If you are an employee, attach your **two most recent pay stubs**
If you are self-employed or an independent contractor, attach Schedule C or Form 1099

☐ I attest that the information I will give here is true and complete to the best of my knowledge.

☐ I attest that I am currently employed and expect to lose wages when I take time off from work for my recovery after the donation surgery, and/or for evaluation and follow-up appointments. I understand I must notify NLDAC if I stop working, and submit new pay stubs if my wages change.

1. How often are you paid?

   ☐ Weekly
   ☐ Every 2 weeks
   ☐ Twice a month
   ☐ Monthly
   ☐ Irregularly/other. Please explain: _____

2. Do you plan to use short-term disability, paid time off, or another program to cover some of your time off work related to your organ donation? If yes, please give as much detail as possible.

   ☐ No
   ☐ Yes: _____

   Note: If paid time off is available to you, you may want to use your paid time off and save NLDAC's support for your travel costs, but NLDAC does not require that you use all of your paid time off before requesting lost wage reimbursement. If you have paid time off but choose not to use it, you will need to inform your employer.

3. For which trips would you like NLDAC to reimburse your lost wages? Only check trips that are in the future.

   ☐ Evaluation (up to 3 days)
   ☐ Surgery and recovery (up to 4 weeks)
   ☐ Follow-up trips (up to 2 weeks)

4. How much of the NLDAC maximum ($6,000 to cover all expenses) would you like to dedicate to lost wages? The rest can be used for travel and dependent care. $_____

Other comments (optional): _____

REQUEST FOR REIMBURSEMENT OF CHILD-CARE OR ELDER-CARE EXPENSES (optional)

Instructions: If you are not applying for reimbursement of child-care or elder-care expenses caused by your organ donation process, skip this page. Otherwise, please follow steps 1 and 2. Call NLDAC at (888) 870-5002 if you have any questions.

Step 1: Complete this page
Step 2: Complete and sign IRS Form W-9

☐ I attest that the information I will give here is true and complete to the best of my knowledge.

☐ I attest that I have at least one dependent (child/disabled adult/elder) who relies on me for care, and by donating an organ I will have to pay for child-care or elder-care that I do not normally pay for. I understand NLDAC will not pay for any care my dependents already receive, like daycare while I am usually at work.

1. How many children (ages 0 – 17) will need care because of your donation? _____

2. On which trips would you like NLDAC to reimburse your **child-care** expenses? Check all that apply:
   ☐ Evaluation (up to 3 days)
   ☐ Surgery and recovery (up to 4 weeks)
   ☐ Follow-ups (up to 2 weeks)

3. How many disabled adults (ages 18 – 64) or elders (65+) will need care because of your donation? _____

4. On which trips would you like NLDAC to reimburse your **elder-care** (this includes people 65 and older, and disabled adults between 18 and 64) expenses? Check all that apply:
   ☐ Evaluation (up to 3 days)
   ☐ Surgery and recovery (up to 4 weeks)
   ☐ Follow-ups (up to 2 weeks)

5. List the children, disabled adults, or elders for whom you will need to arrange alternate care:

Name	Relationship (this person is my...)	Age

6. When will your dependents need alternate care because of your donation? Check all that apply:
   ☐ During the day, Monday through Friday
   ☐ Evenings and/or weekends
   ☐ Irregularly _____

7. How much of the NLDAC maximum ($6,000 to cover all expenses) would you like to dedicate to dependent care? The rest can be used for travel and lost wages. $_____

Other comments (optional): _____

REQUEST FOR REIMBURSEMENT OF TRAVEL EXPENSES (optional)

Instructions: To apply for help with your upcoming travel expenses, complete this page. This section is optional, and you can skip it if you would only like help with lost wages and/or dependent care.

Accompanying Person(s)

*NLDAC can pay for **one** accompanying person to go on two round trips to the transplant center, or **two** people to go on one round trip.*

First accompanying person ☐ Check here if same address as donor			**Second accompanying person** ☐ Check here if same address as donor		
First name:	Last name:		First name:	Last name:	
Date of birth:	Phone:		Date of birth:	Phone:	
Street address:			Street address:		
City:	State:	Zip:	City:	State:	Zip:
Trip(s): ☐ Evaluation only ☐ Evaluation & surgery ☐ Evaluation & follow up ☐ Surgery only ☐ Surgery & follow up ☐ Follow up only			Trip(s): ☐ Evaluation only ☐ Evaluation & surgery ☐ Evaluation & follow up ☐ Surgery only ☐ Surgery & follow up ☐ Follow up only		

Estimated Travel Expenses

	EVALUATION	SURGERY	FOLLOW UP
HOTEL EXPENSES	***Up to 2 nights***	***Up to 14 nights***	***Up to 1 night***
Will the donor require a hotel room/lodging?			
If yes, how many nights?			
Will the accompanying person(s) require a **separate** room?			
If yes, how many nights?			
FOOD EXPENSES:	***Up to 2 nights***	***Up to 14 nights***	***Up to 1 night***
How many nights will the donor/accompanying person(s) be away from home?			
TRANSPORTATION EXPENSES			
How will the donor travel to transplant center? *Air, car, bus, train*			
If driving, how many miles will be traveled round trip?			
How will the companion(s) travel to transplant center? *Air, car, bus, train*			
If companion(s) travels in a **separate car**, how many miles round trip?			
Will the donor need a rental car?			
If yes, for how many days?			
Estimate **daily** cost of parking at hospital, if driving or renting a car			
How many days of parking do you request?			
Estimate tolls *(if any)*	$	$	$
Estimate cost if taking cabs/shuttle/Uber	$	$	$
NOTE: NLDAC can approve additional trips for donor complications or related issues.			
Other information about your travel plans that you would like NLDAC to consider:			

Donor Attestation Form

Transplant professionals: please retain this form in the donor's medical record.

Instructions: Write your name in the blank near the top, read the statements and check all the boxes (except the last one, unless it applies to you), and sign your name at the bottom.

I, _____, as a live organ donor candidate, have truthfully and completely provided all the information requested in the application for reimbursement of travel and subsistence expenses and/or lost wages 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 NLDAC, under Federal law, cannot provide reimbursement to any living organ donor for travel and other 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.
- I give permission for the transplant center to share my information with the National Living Donor Assistance Center.
- I acknowledge that reimbursement may be subject to federal and/or state income tax reporting. Applicant is responsible for contacting a qualified tax advisor to determine tax liability. Neither NLDAC nor other entities providing reimbursement are responsible for any tax consequences of the reimbursement program.
- If this application is approved, I will not request reimbursement of expenses reimbursed in full by NLDAC from any other source (e.g. National Kidney Registry, Alliance for Paired Kidney Donation, Georgia Transplant Foundation, etc.)
- (Only for donors whose recipient is commercially insured by UnitedHealthcare) I give permission to NLDAC to provide the information in this application to other entities, including the recipient's health insurer, for review and potential reimbursement for travel and other qualifying expenses. The health insurer will only use or disclose the information in accordance with the applicable law.

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 travel and 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.

Donor's signature: _____ Date: _____

Transplant center application filer's signature: _____ Date: _____

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** **Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they