



Recipient Attestation Form

Transplant professionals: please retain this form in the recipient candidate'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 transplant 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 transplantation 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.
- (for UnitedHealthcare insured transplant candidates only) I give permission to NLDAC to provide the information in the application to other entities, including my health insurer, for review and potential reimbursement for travel and other qualifying expenses for my donor. The health insurer will only use or disclose this information in accordance with 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.

Recipient's signature: _____

Date: _____

Transplant center application filer's signature: _____

Date: _____



FINANCIAL HARDSHIP WAIVER WORKSHEET – 2024

IMPORTANT: Skip this page if your household income is equal to or below the NLDAC eligibility guidelines.

NLDAC Eligibility Guidelines 350% HHS Federal Poverty Guidelines (FPG) 2024			
Household size	48 Contiguous states and D.C.	Alaska	Hawaii
1	\$52,710	\$65,835	\$60,585
2	\$71,540	\$89,390	\$82,250
3	\$90,370	\$112,945	\$103,915
4	\$109,200	\$136,500	\$125,580
5	\$128,030	\$160,055	\$147,245
6	\$146,860	\$183,610	\$168,910
7	\$165,690	\$207,165	\$190,575
8	\$184,520	\$230,720	\$212,240

Recipients: According to federal law, NLDAC cannot pay for a donor’s travel expenses, lost wages, or dependent care expenses if the recipient can pay those costs. If your household income is above the NLDAC guidelines but you cannot support the donor, you can request NLDAC reconsider your ability to pay by completing this worksheet, which is a financial hardship waiver request. The financial hardship waiver process requires evaluation by the transplant professional, NLDAC and the Health Resources and Services Administration using fact-specific analysis of information captured in the form below. Your allowable out-of-pocket expenses must bring your income within the income guidelines for the application to be approved. For example, if your income is \$5,000 above the NLDAC eligibility guidelines, you will need to demonstrate \$5,000 in allowable annual expenses.

Please list monthly or one-time out-of-pocket expenses for **your entire household**. NLDAC will calculate annual expenses based on the information provided in the worksheet. **Regular living expenses (like rent, utilities, etc.) should not be included.** If you have questions, call NLDAC toll free at (888) 870-5002.

First name:	Last name:
Phone: _____ (NLDAC staff may call you to clarify information on this worksheet.)	

1.	\$	Monthly out-of-pocket medical insurance premiums (medical, dental, vision)
2.	\$	Monthly out-of-pocket pharmacy co-pays before transplant
3.	\$	Monthly out-of-pocket pharmacy co-pays after transplant (Estimated by transplant professional)
4.	\$	Monthly out-of-pocket physician co-pays
5.	\$	Monthly out-of-pocket lab or other medical co-pays not listed above
6.	\$	Total hospital/medical bills owed not covered by insurance (not monthly)
7.	\$	Loss of income due to surgery (excluding paid time off/disability pay) - describe in *Comments
8.	# miles	Monthly round trip mileage for medical appointments (pre-transplant)
9.		How will you travel to the transplant center for your surgery? Air <input type="checkbox"/> Car <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/>
10.	# miles	If driving, how many miles round trip to the transplant center?
11.	yes/no	Will you need to stay in a hotel near the transplant center after your transplant surgery?
12.	# nights	If you will stay in a hotel, how many nights will you stay?
13.	# trips	In the first 3 months after your transplant, how many trips (estimate) will you make to the hospital?
14.	\$	Monthly dependent care for family member not living in the household (ex. child support) - describe in *Comments
15.	\$	Other expenses - describe in *Comments

If loss of income, monthly dependent care for a family member not living in household, or other allowable expenses are noted above, please describe those expenses here. You may attach an additional page if desired.

***Comments:**