



2021 DONOR APPLICATION WORKSHEET

LIVING ORGAN DONATION REIMBURSEMENT PROGRAM

Instructions: NLDAC is a program that helps eligible living 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 must also submit a W-9 and two pay stubs, 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

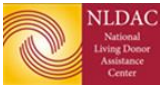
First name	Last name	Date of birth	Social Security number

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

Sex	Race	Ethnicity	Marital status	Education
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Grade school <input type="checkbox"/> High school/GED <input type="checkbox"/> Post HS/tech or trade <input type="checkbox"/> Some college <input type="checkbox"/> 4-year college <input type="checkbox"/> Post college/professional
Employment status		Organ	Please answer:	
<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> On disability leave <input type="checkbox"/> Retired	<input type="checkbox"/> Homemaker/caretaker <input type="checkbox"/> Student <input type="checkbox"/> Unemployed	<input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Uterus	Are you a U.S. citizen or lawfully present resident? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you signed the NLDAC Attestation Form? (see page 4) Yes <input type="checkbox"/> No <input type="checkbox"/> The NLDAC Program will make it possible for me to be an organ donor. Yes <input type="checkbox"/> No <input type="checkbox"/> Are you self-employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Relationship to transplant candidate			
I am the _____ of the recipient. <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
If <i>other</i> , please specify:			
TYPE OF RELATIONSHIP: <input type="checkbox"/> Blood related <input type="checkbox"/> Non-blood related (by marriage, in-law, etc.) <input type="checkbox"/> Unrelated			
Address <input type="checkbox"/> Check if donor and recipient live at the same address.			
Street:	City:	State:	Zip:
Location: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural			
Cell:	Alt. phone:	Email address:	
<i>If application is approved, we will send approval letter by email</i>			
Send reimbursement to address of primary residence? Yes <input type="checkbox"/> No <input type="checkbox"/> 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.	
<input type="checkbox"/> Federal income tax return - most recent year (use adjusted gross income) <input type="checkbox"/> Pay stubs (use gross income) <input type="checkbox"/> W2 (use gross income) <input type="checkbox"/> Government assistance program (HUD, WIC, SNAP)	<input type="checkbox"/> Medicaid eligibility <input type="checkbox"/> Social Security benefits statement <input type="checkbox"/> 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 or paid time off to cover some of your time off work related to your organ donation? If yes, please explain.

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 maximum NLDAC reimbursement (\$6,000 to cover travel, lost wages, and dependent care) would you like to reserve for reimbursement of your lost wages? NLDAC can reimburse up to 4 weeks of lost wages for surgery and recovery time. \$_____.

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, read the two statements below carefully, check the boxes to indicate you agree, and answer questions 1 – 7. Call NLDAC at 888-870-5002 if you have any questions.

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 at 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 maximum NLDAC reimbursement (\$6,000 to cover travel, lost wages, and child- or elder-care) would you like to reserve for child- or elder-care expenses? \$ _____

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 trips to the transplant center, or *two* people to go on one trip.

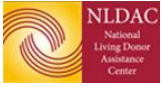
First accompanying person <input type="checkbox"/> Check here if same address as donor			Second accompanying person <input type="checkbox"/> Check here if same address as donor		
First name:	Last name:		First name:	Last name:	
Date of birth:	Phone:		Date of birth:	Phone:	
Street address:			Street address:		
City:	State:	Zip:	City:	State:	Zip:
<input type="checkbox"/> Evaluation only <input type="checkbox"/> Evaluation & surgery <input type="checkbox"/> Evaluation & follow up		<input type="checkbox"/> Surgery only <input type="checkbox"/> Surgery & follow up <input type="checkbox"/> Follow up only	<input type="checkbox"/> Evaluation only <input type="checkbox"/> Evaluation & surgery <input type="checkbox"/> Evaluation & follow up		<input type="checkbox"/> Surgery only <input type="checkbox"/> Surgery & follow up <input type="checkbox"/> Follow up only

Estimated Travel Expenses

	EVALUATION	SURGERY	FOLLOW UP
HOTEL EXPENSES	<i>Up to 2 nights</i>	<i>Up to 14 nights</i>	<i>Up to 1 night</i>
Will the donor require a hotel room/lodging?			
If yes, how many nights?			
Will the accompanying person require a separate room?			
If yes, how many nights?			
FOOD EXPENSES: COMPLETE ONLY IF HOTEL IS NOT REQUESTED:	<i>Up to 2 nights</i>	<i>Up to 14 nights</i>	<i>Up to 1 night</i>
How many nights will the donor/accompanying person be away from home?			
TRANSPORTATION EXPENSES			
How will the donor travel to transplant center? <i>Air, car, bus, train</i>			
If driving, how many miles will be traveled round trip?			
How will the companion(s) travel to transplant center? <i>Air, car, bus, train</i>			
If companion 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 <i>(if any)</i>	\$	\$	\$
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 for travel expense, lost wage, and/or dependent care reimbursement is approved, I will not request reimbursement of these costs from any other source (e.g. National Kidney Registry, Alliance for Paired 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: _____



2021 RECIPIENT APPLICATION WORKSHEET LIVING ORGAN DONATION REIMBURSEMENT PROGRAM

Instructions: NLDAC is a program that helps living donors with their travel expenses, lost wages, and dependent care expenses if their recipient cannot afford to do so. 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. 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. If this application is not approved, the recipient can provide financial assistance to the donor. While the National Organ Transplant Act (NOTA) prohibits the buying and selling of organs, it allows reasonable payments associated with the expenses of travel, housing, lost wages, and dependent care incurred by the donor of a human organ.

First name	Last name	Date of birth	Social Security number

Street address		
City	State	Zip code

Sex	Race	Ethnicity
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic

Are you a U.S. citizen or lawfully present resident? Yes No

Have you signed the Attestation Form? (See page 6) Yes No

Are you currently on dialysis? Yes No

Does your health insurance provide a travel benefit for your living donor? Yes No

If yes, what benefits are covered by your insurance (e.g. hotel, transportation, meals?)

If your health insurance provider is UnitedHealthcare, look at the bottom right of your insurance card. Does it say, "Underwritten by UnitedHealthcare?"

If yes, list the policy number: _____, member ID: _____ and policy holder's name to verify coverage.

If it says, "Administered by UnitedHealthcare Services, Inc.", is one of the following listed below "Group Name":
 UnitedHealth Group, Inc.; Optum Care, Inc.; Optum360 Services, Inc.?

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.

<input type="checkbox"/> Federal income tax return - most recent year (use adjusted gross income) <input type="checkbox"/> Pay stubs (use gross income) <input type="checkbox"/> W2 (use gross income) <input type="checkbox"/> Government assistance program (HUD, WIC, SNAP) <input type="checkbox"/> Medicaid eligibility <input type="checkbox"/> Social Security statement <input type="checkbox"/> Other document - (i.e. disability statement, etc.)
--



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 – 2021

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) 2021			
Household size	48 Contiguous states and D.C.	Alaska	Hawaii
1	\$45,080	\$56,315	\$51,870
2	\$60,970	\$76,195	\$70,140
3	\$76,860	\$96,075	\$88,410
4	\$92,750	\$115,955	\$106,680
5	\$108,640	\$135,835	\$124,950
6	\$124,530	\$155,715	\$143,220
7	\$140,420	\$175,595	\$161,490
8	\$156,310	\$195,475	\$179,760

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 1-888-870-5002.

First name:	Last name:
Phone: <i>(NLDAC staff may call you to clarify information on this worksheet.)</i>	

1.	\$	Monthly out-of-pocket insurance premiums
2.	\$	Monthly out-of-pocket pharmacy co-pays before transplant
3.	\$	Monthly out-of-pocket pharmacy co-pays after transplant <i>(Estimated by transplant professional)</i>
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 <i>(not monthly)</i>
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:**