LIVE ON Organ Donation, Inc. (LIVE ON) provides financial assistance to living organ donors and their recipients in the form of grants to defray non-medical unavoidable costs that arise during the living organ transplant process.

To apply for a grant, this completed application must be submitted to LIVE ON by a transplant center social worker on behalf of a donor. LIVE ON does not accept applications from other persons.

Applications should generally be submitted about a month before surgery. Grants are generally made on or about the day of surgery. LIVE ON does not reimburse for expenses incurred prior to the date of the application.

GENERAL INFORMATION

First Name	Last Name	Date of Birth	

Gender	Race (optional)	Ethnicity (optional)	Marital Status	Dependents at home
☐ Male ☐ Female	☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/other Pacific Islander	☐ Hispanic ☐ Not Hispanic	☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed	

Organ	Employment		Citizenship
☐ Kidney ☐ Liver ☐ Lung	☐ Employed Full Time ☐ Employed Part Time ☐ On Disability Leave ☐ Retired	☐ Full-time at home parent ☐ Student ☐ Unemployed	Are you a U.S. citizen or lawfully admitted resident? Yes ☐ No ☐

***For Donors*: RELATIONSHIP TO ORGAN RECIPIENT**	
Relationship to Organ Recipient: ☐Father ☐Mother ☐Sister ☐Brother ☐Son ☐Daughter ☐Spouse ☐Other	
If *Other*, please specify:	
☐ Blood Relative ☐ Non-Blood Relative ☐ Unrelated	

CONTACT INFORMATION ☐ Donor and Recipient live at the same address.

Primary Residence Address			
Street		City	
State	Zip Code		
Phone		Alt. Phone	
Email			
Send reimbursement to Primary Residence? Yes ☐ No ☐ **If no, provide address for reimbursement:**			
Street		City	
State		Zip Code	

INCOME INFORMATION

Annual Household Income		Dependents in Household	
	$		#
	Please attach as an indicator of household income three recent monthly bank statements of the one or more accounts into which household is deposited. Please feel free to provide a ***maximum one page*** attachment to provide any information you consider material that influences your need for assistance, such as, for example, commitments to college tuition or other similar material financial obligations.		

PERSON(S) WISHING TO ACCOMPANY PATIENT

First Accompanying Person ☐ Address is the same as primary residence address, above							
First Name				Last Name			
Date of Birth		Address					
City		State		Zip		Phone	
Which Trip(s)?	☐ Evaluation Only ☐ Evaluation and Surgical Procedure ☐ Evaluation and Medical Follow up ☐ Surgical Procedure Only ☐ Surgical Procedure and Medical Follow up ☐ Medical Follow up Only						
Second Accompanying Person ☐ Address is the same as primary residence address, above							
First Name				Last Name			
Date of Birth		Address					
City		State		Zip		Phone	
Which Trip?	☐Evaluation Only ☐Surgical Procedure Only ☐Medical Follow up Only						

COST ASSESSMENT

Travel-Related Expenses*:* For those who need assistance with travel-related expenses, please complete the expense estimates below based on your best judgment.

Other Unavoidable Expenses: For those who need assistance with other non-medical expenses, such a for example, the costs of a helper post-surgery, child-care, pet care, or other unavoidable expenses associated with surgery, please provide a ***one page maximum*** separate statement that identifies the expected need, the identified cost per day, the expected number of days and any other detail you consider material.

	Evaluation Trip	Surgery Trip	Follow-up Trip
HOTEL EXPENSES			
1. a. Will the donor/recipient require a hotel room?			
b. If yes, how many nights anticipated?			
2. a. Will accompanying person require a separate room?			
b. If yes, how many nights?			
PER DIEM/FOOD EXPENSES			
If no hotel needed, please provide the number of days of meals for Donor/Recipient and Accompanying person			
TRANSPORTATION EXPENSES			
1. a. What is patient's means of travel to Center? *Air, Car, Bus*			
b. If by car, number of miles round trip?			
2. a. What is accompanying person means of traveling to			
b. If traveling in a separate car, how many miles round trip?			
3. a. Estimate daily parking costs (Center, Hospital, and/or	*$*	*$*	*$*
b. How many days of parking anticipated?			
4. a. Estimate other ground transportation costs - See 4.b.	*$*	*$*	*$*
b. Type: Rental Car, Tolls, Cab, Shuttle, Other			

A Sense of Circumstance

	Yes	No
I have accrued and/or have current paid vacation or sick time through my employer. Amount of paid time off available, current plus accrued: _____	☐	☐
I have short-term disability benefits through my employer.	☐	☐

ORGAN DONOR CANDIDATE

Attestation Form

Live On Organ Donation Inc. will not process an application for financial assistance from organ donor candidates until it receives a signed attestation form.

Transplant Centers - Please retain this form in patient medical record

I, _____, a live organ donor candidate, have truthfully and completely provided all the information requested in the application for reimbursement of non-medical expenses associated with 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 provides, 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 LIVE ON Organ Donation Inc. does not provide funds to any living organ donor for expenses if the donor can receive reimbursement for those expenses from any of the following sources; (1) A 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 that all the information I have provided is true, correct and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Transplant Center Application Filer: _____ Date: _____