Second Chance at Life

Transplant Related Expenses & Insurance Grants

The following list is reasonable transplant related expenses that the organization will fund. Which one(s) are you applying for? Please check all that apply.

- ☐ Prescription drugs necessitated by the transplant for the patient.
- ☐ Medical bills and/or co-pays related to the transplant patient.
- ☐ Dental assistance for pre-transplant candidate.

These items are not considered transplant expenses and will not be reimbursed:

* Entertainment items
* Clothing
* Personal Products
* Rehab therapy not administered by a licensed therapist
* Postage
* Auto repairs
* Computers
* Loss of income
* Expenses unrelated to transplant

Please note this is not a completed list of expenses and the charity does not reimburse the individual.

Guidelines for funding: In order for your application to be considered, the following items need to accompany your application:

☐ Proof of Michigan residency during the last twelve months prior to this application date. Proof of residency can be a utility bill, bank statement or a driver's license with the expiration date.

☐ Proof of Income – You may either enclose a copy of the most recent State Income Tax or a most recent check stub or social security income statement.

☐ Proof of Health Insurance if applicable – A copy of your Medicare, Medicaid or private insurance card. If you don't have health insurance, please note that you have no insurance.

☐ Invoices/quotes for all medical related expenses that you are seeking the charity to pay the company/creditor directly: Examples: Copy of medication prescribed and costs, copy of medical invoice or quote from dental office.

Date of Application: _____

Applicant's Signature: _____

Please Print Name: _____

Phone Number: _____

Second Chance at Life

Client Information Section:

First Name | Middle | Last Name

Street Address | Apt./Suite Number

City | State | Zip Code | County

Home Phone | Cell Phone | E-Mail

Date of Birth | Age

☐ Male ☐ Female ☐ Married* ☐ Single

* If married, please provide your spouse's name _____

Number in Household | Number of Children (living in household)

Demographical Information:

Transplant Center | Date of Transplant | Organ

Current Source of Income (Please check all that apply)

☐ Full-Time employment ☐ with benefits ☐ Social Security Disability (SSDI)
☐ Part-Time employment ☐ with benefits ☐ Supplemental Security Income
☐ Other _____

Current Healthcare Coverage – Please list what type of insurance you have, if none, state none.

Check all that apply:

☐ Recipient ☐ Candidate ☐ Living donor

How did you hear about Second Chance at Life? _____

Do not leave any field blank

Financial Assistance Application

Assets Do not leave any field's blank in this section

Checking Account $_____
Savings Account $_____
Retirement $_____
Other $_____

Monthly Household Income *(please read below)		**Monthly Household Expenses** *(please read below)	
Wages (net)		**Rent/Mortgage**	
Social Security		**Food**	
Pension		**Utilities Total**	
Spouse's Income		**Auto Payment/Gas**	
Retirement Income		**Insurance – Medical**	
Dividends if applicable		**Insurance – Life**	
Other (specify)		**Insurance – Auto**	
		Charge Accounts	
		Other	

Total Monthly Income: _____ Total Monthly Expenses _____

I authorize information released between Second Chance at Life and my transplant Center or other related parties to verify information related to this request. I agree to be added to Second Chance at Life for future mailings.

_____
Applicants Signature Date

If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month: _____
_____
_____
_____

* **Income:** Total amount for wages or salary, self-employment, pensions, rental income, income from lawsuit, unemployment income, Social Security, Social Security Disability Income, child support, public assistance and any income from working spouse, children, parents, siblings, grandparents, renters or any other person(s) related or non-related residing in your household.
* **Expenses**: General household expenses per month-rent/mortgage, food, utilities, phone, credit card(s) monthly amount paid (not balances owed).

Patient's Name: _____

Check(s) Payable to: (List name of payee and attached supporting documents)

1. _____ Amount _____

2._____ Amount _____

3. _____ Amount _____

4. _____ Amount _____

Total Amount Requested: _____

You may attach on a separate sheet a list of additional items to be paid and amount if needed.

Social Worker's Statement:
(Please document fully the background information creating the need and your recommendations)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Requesting Social Worker: _____

Transplant Center: _____

Contact Information: _____

- ***All checks will be paid directly to the companies/creditors listed above.***
- ***Please remember to attach your supporting information***
- ***Please verify financial information is correct***
- ***Please mail applications to 32591 Judy Drive, Westland, Michigan 48185 or fax to (734) 293-2640, Attn: Second Chance at Life***