Organ Recipients Association of Arkansas, Inc.
Transplant Patient Assistance Fund

Patient Assistance Fund Guidelines and Application Instructions

Purpose: The Organ Recipients Association of Arkansas, Inc. (ORA/AR) Patient Assistance Fund (Assistance Fund) is intended to be a charitable provider of limited financial assistance as a once a year partial bridge to help transplant patients living in Arkansas get through a financial shortfall. It is designed to help pay for medical and other related expenses that are of an emergency or non-insured nature. Per request and annual limits will apply to all funding requests. Since funds are distributed from charitable donations, assistance will only be provided when funds are available. All applications are submitted to a review process to determine whether funds will be granted.

Eligibility: In order to apply for assistance an applicant must meet the following criteria:

- Must be a transplant patient or the legal guardian of a minor transplant patient with permanent residence in the state of Arkansas.
- Patient must be either post-transplant, on a waiting list for a transplant, or in the transplant evaluation process.
- Must be a member of the Organ Recipients Association of Arkansas, Inc. (application attached).
- Must have a medical or other related need for financial assistance which is of an emergency or non-insured nature.
- The applicant or guardian cannot have a total annual household income of more than $45,000. Extenuating circumstances may be considered and should be listed; i.e., number of family members, costs of care, etc.
- The application for assistance must be verified by either the Social Worker or Transplant Coordinator on your transplant team.
- If applying for a bill to be paid, a copy of the bill or formal cost estimate are requested.
- Must complete the Patient Assistance Fund Application and Release Form and submit to Social Worker or Transplant Coordinator to be forwarded to the fund administrator.

Please read the following instructions carefully to properly complete the attached ORA/AR Assistance Fund application. If all sections of the packet are not fully completed, it may be returned and the applicant not considered for assistance until completed. Please do not separate the pages of this packet.

1. Complete the appropriate sections of the application form. Retain pages one and two and make a copy of the application for your records.
2. Forward the packet to your transplant center for confirmation of your status.
3. Patient/Guardian must sign on Page 3. Social worker or Transplant Coordinator must sign page 4.
4. After your transplant team has completed the Transplant Center Verification page, they will forward the packet to ORA/AR.
5. All information is held secure and confidential.

Applications for less than $500 may be processed by the fund administrator. Request for more than $500 will be processed by a committee within ORA/AR. Any distribution of funds will normally be made payable to the billing agency in the form of a check and forwarded directly to the billing agency. Amounts will be specific quantities and not for general lump sums.

Transplant Center personnel can submit the completed and verified application to ORA/AR by:

1. U.S. Mail to the following address:
   Organ Recipients Association of Arkansas, Inc.
   P. O. Box 250607
   Little Rock, AR 72225-0607
2. By sending a scanned copy of the application by email to: billbrass39@gmail.com
3. By faxing the application (501) 375-1316.

To avoid unnecessary delays, be sure all parts of this Application Packet are completed according to the instructions and DO NOT SEPARATE the pages. If financial assistance is needed quickly, please call Bill Brass at (501) 590-7427 for notification of submission and expedited review of request.

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Transplant Patient Application

Patient's Name: Last _____ First _____ Middle _____

Permanent Address _____ City _____ State _____ Zip _____

Temporary Local Address _____ City _____ State _____ Zip _____

Date of Birth_____ Marital Status_____ Social Security #_____

Contact Phone #_____ Alternate Phone #_____

Diagnosis_____ Organ_____

Spouse's Name (or Parent or Guardian)_____

Number of Dependents and Ages_____

A. HOUSEHOLD INCOME:

Monthly Take-Home Pay (applicant or Guardian)	$_____
Disability Insurance	$_____
Spouse's Take-Home Pay	$_____
Other Household Member's Income	$_____
Social Security Disability Income (SSDI)	$_____
Pension/Retirement	$_____
Other Government Benefits	$_____
Other Income: Unemployment, etc.	$_____
TOTAL MONTHLY HOUSEHOLD INCOME	$_____

Does Patient have the following? (Circle One)

- Medicare Yes No
- Medicaid Yes No
- Insurance Yes No
- Prescription drug coverage through Insurance Yes No
- What is your co-pay? _____

B. EXPENSES	TEMPORARY RESIDENCE	PERMANENT RESIDENCE
Rent or Mortgage	$_____	$_____
Telephone	$_____	$_____
Electricity/Gas/Heating Fuel	$_____	$_____
Water/Sewer	$_____	$_____
Heat	$_____	$_____
Other	$_____	$_____
TOTAL MONTHLY EXPENSES	$_____ +	$_____ = $_____

On a separate sheet, please detail the specific assistance needed. If possible, please type. If your request is for assistance with a medication, please provide drug name, dose and frequency.

Applicant/Guardian Signature **X**_____Date_____

****All information is held secure and confidential****