THE EQUITY IN HEART TRANSPLANT PROJECT

Patient Assistance Request Form

PLEASE NOTE: ALL PATIENT INFORMATION IS KEPT CONFIDENTIAL. DEIDENTIFIED INFORMATION WILL BE SAVED IN OUR SECURE DATABASE TO KEEP TRACK OF OUR FUNDING EFFORTS.

This form must be filled out in its entirety by a member of the patient's healthcare team that is directly involved in the heart transplant evaluation process. This form cannot be filled out by the patient or their family/caregiver.

Today's Date:

Patient's Information

First Name Last Name

Country of Birth Date of Birth

Race (must be confirmed by patient or family)

Native American Native Indian/Alaska Native Hawaiian or Other Pacific Islander

Asian Black White Other (must specify):

Ethnicity (must be confirmed by patient or family)

Hispanic/Latinx Non-Hispanic/Latinx Other (must specify):

Gender

Woman Man Transgender woman Transgender man Non-binary

Other: Prefer not to answer

Patient Contact Info

Street City State Zip

Phone Number

Transplant Center

Type of insurance

Commercial Medicaid Medicare Veterans Administration

Hospital philanthropic fund None

Information of cardiologist directly involved in the patient's heart transplant evaluation

First Name Last Name

Email Phone #

Person filling out this form

First Name Last Name

Title Relationship to the patient

Email Phone #

Medical information

Diagnosis resulting in end-stage heart failure:

Has the patient been listed for heart transplant? Yes No

Please describe patient's financial need. You must specify how funds will be used (for example, transportation, lodging, deductibles, etc.…) or application will be considered incomplete and returned to you. (<500 words, in details)

What fundraising efforts, if any, has the patient or their family undertaken so far? What was the result of these efforts? (<200 words)

Annual household income

<$20,000 $20,000- $39,999 $40,000- $59,999

$60,000- $79,999 ≥$80,000 (ineligible for grant funding)

Grant amount requested $

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This space is for patients and their families to share any additional information they think might be helpful to us (optional)

By checking this box, I certify that all institutional sources of funding have been exhausted

By checking this box, I certify that this patient is/will be listed for heart transplant pending this financial assistance

By checking this box, I give permission to The Equity in Heart Transplant Project to reach out to me (the patient) post-transplant to see how I am doing

Full name of individual filling out this form

Signature of individual filling out this form

Signature of patient or their representative

Date (MM/DD/YYYY)

By signing this form, we hereby certify that, to the best of our knowledge, the provided information is true and accurate.

The Board of Directors meets on the second Monday of each month to discuss grant requests. You will be notified of the status of your request after this meeting.