



Rhode Island Organ Transplant Fund Application for Benefits

IMPORTANT:

*Please review the **Eligibility Brochure** before completing this application.
Complete all sections and print clearly if completing by hand.*

SECTION 1 - APPLICANT INFORMATION

Applicant Name _____ Telephone # _____

Street/Address _____ Email (*optional*) _____

City/Town _____ Zip Code _____

Sex: Male Female Other

Marital Status: Single Married Divorced Widowed

Is the applicant a minor, under guardianship, or someone other than the recipient?

No (The applicant is the recipient)

Yes (Appropriate documentation may be required)

If yes, what is the relationship to recipient(Required)

Parent Spouse Adult Child Legal Guardian Authorized Representative

Other Family Member Legal Representative/Attorney Other _____

Dependents (please list below):

Name	Date of Birth	Relationship to Applicant

SECTION 2 – TRANSPLANT RECIPIENT INFORMATION

Is the transplant recipient the applicant? Yes No

Recipient Name (if different): _____

Rhode Island Resident? Yes No

If yes, how long: _____

SECTION 3 – MEDICAL INFORMATION

Diagnosis: _____

Type of Transplant: _____

Actual or Estimated Transplant Date: _____

Transplant Center Name/Address: _____

SECTION 4 – INSURANCE INFORMATION

List all health insurance plans covering the transplant recipient – including Medicare and Medicaid:

Covered Member: _____

Insurance Provider: _____

Policy Number: _____

Effective Date: _____

Has the transplant recipient or any family member applied for, enrolled in, or been deemed eligible for any state or federal programs that provide financial assistance or medical coverage for organ transplant- related services?

Yes: No:

If yes, please explain:

List approximate current family income from all sources below:

Name	Income Source	Gross Monthly Amount

I hereby certify the accuracy of the information supplied herein and authorize any insurance company, prepayment organization, non-profit hospital and medical corporation, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under the Rhode Island Organ Transplant Fund. I permit a copy of this authorization to be used in place of the original. I understand that failure to provide information, which is true, correct and complete is in violation of the Laws of the State of Rhode Island. I understand that benefits for this program are subject to available funding.

Signature of Client

Date

Signature of Spouse

Date

Signature of Parent/Guardian/Authorized Representative/
Power of Attorney

Date

RELEASE OF INFORMATION AUTHORIZATION

Instructions to Applicant:

Please complete **SECTION 1** and return with the application to the following address:
Rhode Island DHS – Medicaid & LTSS Unit P.O. Box 8790, Cranston, RI 02920.

If you are married, both you and your spouse must sign this form.

SECTION 1

Name: _____

Address: _____

Applicant Social Security Number: _____

Spouse's Social Security Number: _____

I hereby authorize the Rhode Island Division of Taxation to share my, or the applicant's Adjusted Gross Income (AGI) and total number of exemptions to the Rhode Island Department of Human Services for the purpose of verifying eligibility for the Organ Transplant Fund. This information will be used solely to determine eligibility for transplant-related assistance.

Signature of Applicant

Date

Signature of Spouse

Date

Signature of Parent/Guardian/Authorized Representative/
Power of Attorney

Date

SECTION 2A (To be completed by the Rhode Island Division of Taxation)

Name (Applicant): _____ SS#: _____

Name (Spouse): _____ SS#: _____

Adjusted Gross Income: _____

Total Number of Exemptions: _____

Year: _____

Authorized Signature - Division of Taxation Representative

Date

SECTION 2B (To be completed by the Rhode Island Division of Taxation)

Name (Parent 1 of child): _____ SS#: _____

Name (Parent 2): _____ SS#: _____

Adjusted Gross Income: _____

Total Number of Exemptions: _____

Year: _____

Authorized Signature - Division of Taxation Representative

Date

For Official Use Only

(To be completed by DHS reviewing staff only)

Date Received: _____

Reviewer Name: _____

Eligibility Verified: Yes No

Criteria Met: Yes No

Additional Information Required:

Yes No → If yes, specify: _____

Decision:

Approved Denied Pending Additional Review

Reviewer Notes:

Authorized DHS Signature: _____ Date: _____