

# Fletcher Fund Application

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Attached is an application for the Organ Recipients of SW Fl. Inc.'s Fletcher Fund.

Individual disbursements are currently capped at \$300.00. Yearly disbursements are currently capped at \$1,500.00. Only members of Organ Transplant Recipients of SW Fl. may apply.

Applications for group 1 expenses will receive the highest priority. Group 2 expenses will receive middle priority and group 3 expenses will receive lowest priority.

**Group 1** (High Priority)

Medications and Medical Related Expenses

**Group 2** (Middle Priority)

Lodging, Meals, and Transportation To and From Medical Facilities

**Group 3** (Low Priority)

Household and Transplant Miscellaneous Expenses

Completed applications delivered to any Fletcher Fund Trustee will be considered at the Trustee's next regularly scheduled meeting.

# Fletcher Fund Request for Assistance

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## ***PERSONAL INFORMATION***

Name: \_\_\_\_\_ Full time or part time resident? \_\_\_\_\_

Local Address: \_\_\_\_\_ Alternative Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Caregiver's Name \_\_\_\_\_

Present Employer: \_\_\_\_\_ Caregiver's Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Caregiver's Home Phone: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Caregiver's Cell Phone: \_\_\_\_\_

## ***FINANCIAL INFORMATION***

Combined Monthly Household Income – After Taxes

Wages: \$ \_\_\_\_\_

Social Security: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

Disability: \$ \_\_\_\_\_

Investments: \$ \_\_\_\_\_

<i>OTHER FINANCIAL RESOURCES</i>	<i>ESTIMATED TOTAL MONTHLY LIVING EXPENSES &amp; LIABILITIES</i>
Previous Fundraising Activities:     \$ _____	Do you rent or own your residence? _____
Total Liquid Assets (stocks, bonds etc.): \$ _____	Monthly Rent or Mortgage:             \$ _____
Other:                                     \$ _____	Average Total of Monthly Utilities: \$ _____
	Monthly Vehicle Payment                \$ _____
	Monthly Med Insurance Payment:     \$ _____
	Monthly Other:                            \$ _____

***PATIENT INSURANCE INFORMATION***

Medical ins. name: \_\_\_\_\_ Insurer ph. number: \_\_\_\_\_

Policy name & number: \_\_\_\_\_ Date issued: \_\_\_\_\_

Will health insurance provide coverage: \_\_\_\_\_

If yes, in what capacity? 100% \_\_\_\_\_ 90/10 \_\_\_\_\_ 80/20 \_\_\_\_\_ Other \_\_\_\_\_

If no, please provide insurer determination letter.

Does insurance provide a travel and/or lodging benefit? \_\_\_\_\_

If yes, what limit? \_\_\_\_\_

Life insurance amount? \_\_\_\_\_ Insurer/Company name: \_\_\_\_\_

Policy name & number \_\_\_\_\_ Date Issued: \_\_\_\_\_

***PATIENT TRANSPLANT INFORMATION***

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Type of Transplant \_\_\_\_\_

Are you on a transplant waiting list? \_\_\_\_\_

Have you already received a transplant? \_\_\_\_\_ If so date of transplant: \_\_\_\_\_

Transplant Center? \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

***REQUEST INFORMATION***

Amount requested: \$ \_\_\_\_\_ for payment to \_\_\_\_\_

Reason for the request: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach all relevant bills, invoices and/or insurance explanation of benefits forms.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

**AUTHORIZATION OF RELEASE INFORMATION**

**I HEREBY AUTHORIZE** the Fletcher Fund complete and total access to any and all records confidential or otherwise needed to determine my eligibility. Any person in possession of any record or information about me upon presentation of this Authorization is hereby instructed to furnish copies of my complete file and any other information.

\_\_\_\_\_  
Print Name / Signature

\_\_\_\_\_  
Date