Second Wind Lung Transplant Association, Inc.

FINANCIAL ASSISTANCE FUND TRANSPLANT CENTER VERIFICATION

To be completed by Social Worker, Transplant Coordinator or Financial Coordinator.

Please review this patient's application for financial assistance and provide us with the following information. This information, along with your comments and recommendations, will enable Second Wind to fully evaluate this application. Please complete every item. Where an item does not apply, please indicate not applicable by entering **N/A.**

Applicant's Name: ________________________________ **Diagnosis**: _______________________

- Has this patient received a lung transplant? YES NO
- If yes, when was the patient transplanted? Month_______ Day ________ Year _________
- Is this patient compliant with his/her medication regimen? YES NO
- Has this patient raised funds to help cover transplant and related expenses? YES NO
- If known, how much has been raised? $_______________

Please provide your comments, recommendations, and any history regarding this patient's need for financial assistance. Point out any extenuating circumstances and costs associated with this patient's treatment, such as transportation, away-from-home living expenses, home medical supplies and costs of medicines, etc. (Use additional page if necessary.)

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Name and title of team member completing this section. ____
(PLEASE PRINT)

Transplant Center Name: ____

Center Address: ____
Street City State Zip

Team Member Signature X __________________________________ Date: ________________

Telephone # (_____) ______________________ Fax # ( ) _______________________

All information is held secure and confidential.

Team Member please forward to Second Wind using stamped, addressed envelope provided by Applicant.