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 # ( ) _____

Email address of team member completing this form _____

All information is held secure and confidential.

Team Member please forward this form to Second Wind along with member application and Patient Release form to either: email phenry2ndwind@gmail.com or fax (760) 690-4490 or mail to Patrick Henry 75 Scattertree Lane, Orchard Park, NY 14127