Fletcher Fund
Patient Assistance Request Form

Patient Information Application Date: _____

First Name: _____ Last Name: _____

Residence (City, State): _____ Date of Birth: _____

☐PRE ☐POST ☐LIVING DONOR Transplant Type: _____ Transplant Date: _____

Type of Assistance Needed: _____

Total Amount Requested: $_____ Payment to be made to: _____

Nature of Financial Situation: _____

_____

_____

Health Insurance: _____ Amount Covered: $ _____

Total Monthly Income $ _____ Source(s) _____

Monthly Expenses:	Amount	Monthly Expenses:	Amount
		Total	

Previous Support by the **Fletcher Fund**? ☐YES ☐ NO Date _____ Amount $ _____

Financial Resources Used to Date (family, savings, charities, etc.): _____

Is patient able to contribute for the purpose of the request? ☐YES ☐ NO If yes, how much? $ _____

Please attach any additional information that may pertain to request. Additional documents may be required pending the type of request.

Transplant Center Information

Transplant Center: _____ Phone #: _____

Physician/Surgeon Name: _____ Phone #: _____

Requestor Name: _____ Title: _____

Email: _____ Phone Number: _____

PLEASE NOTE: DO NOT PROMISE PAYMENT

Submitting a request does not guarantee approval. Each field above must be completed in order for application to be considered. Please allow at least 5 business days for application to be processed.

Annual disbursements are capped at $1,500. Priority is given to medication and medical expenses.

Submit requests or questions to: Donna Williams - dwmson79@gmail.com or Mike Terry - mterry1015@aol.com

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FOR FLETCHER FUND USE ONLY

Approval: _____ Date: _____

Payment Type: ☐CHECK ☐CREDIT CARD ☐GIFT CARD ☐OTHER Payment Date(s): _____

Notes: _____

_____

Date Received: _____ Revised 1/10/2018