Application For Reimbursement
Living Donor Support Program

Please fill out this application for reimbursement form each time you are requesting reimbursement and attach the applicable forms for the types of reimbursement(s) being requested.

Living Donor's First Name	Last Name	Date of Birth

Transplant Center: _____

Applicant Number (given at time of eligibility approval)**:** _____

What phase in the living donation process is this reimbursement application for?
(select more than one phase if applicable to your request)

- ☐ Evaluation/pre-surgical
- ☐ Surgical/recovery
  Date of Surgery: _____
- ☐ Follow-up
  Date(s) of appointments (mm/dd/yyyy): _____

When applying for reimbursement in this phase please identify the outcome of your evaluation (if known)**:**

- ☐ Transplant Center approved me to proceed with surgery
- ☐ Transplant Center did not approve me to proceed with surgery
- ☐ Other, please explain: _____

Please tell us about your expenses. Detailed receipts and verification of appointment(s) from your transplant center are needed along with this application to complete a full review.

What expenses are you seeking reimbursement for in this claim? (check all that apply)

- ☐ Reimbursement of dependent care expenses
- ☐ Unreimbursed medical care and/or medication
- ☐ Reimbursement of support person
- ☐ Lost wages or cost of lost time
- ☐ Reimbursement of travel/lodging expenses for self

Please skip any types of reimbursement sections that are not applicable to the expenses that you are seeking *at this time*.

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Application #:	**Applicant #:**

CHILDCARE

The Living Donor Support Program reimburses childcare expenses incurred by the living donor due to having to pay someone to provide care to their child(ren), that the living donor normally provides but due to the living donation process is unable to provide the care themselves. The Living Donor Support Program does not reimburse expenses for childcare provided by others that were in place prior to the start of the living donation process. There is a specific child with a disability, dependent adult and elder care form as their rates and reimbursement vary. Please make sure you select the appropriate form.

New York State-Living Donor Support Program
CHILDCARE Reimbursement Form

Name of individual(s) receiving care	Date of Birth
Dependent care provider(s) name	**Provider relationship to child(ren)**

The Living Donor Support Program has set maximum rates of reimbursement for childcare. For care provided for more than one child the reimbursement will be at a rate that is equivalent to the "Under 2 category".

Please indicate the date (mm/dd/yyyy) **and number of hours that childcare was provided on that day:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
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AFTER READING THE STATEMENTS BELOW PLEASE SIGN AND DATE YOUR DESIGNATED SECTION

I attest that I have at least one dependent child who relies on me for care, and through the living donation process I have had to pay for childcare that I do not normally pay for. I understand the Living Donor Support Program will only pay for additional care my dependents needed from others due to the demands of the living donor process on me, not, for example care they may already receive while I am usually at work.

Living Donor Signature: _____ **Date:** _____

I attest that the information provided on this form is accurate and that childcare was performed by myself for the dates and hours recorded.

Provider Signature: _____ **Date:** _____

CERTIFICATION	
I hereby certify that the above is just, true and correct, and that the amounts claimed were necessary and incurred during the process of living donation.	
Signature:	**Date:**

FOR AGENCY USE ONLY		
Expense Report Number:	**Travel Authorization Code:**	
Entered by:		**Date:**

OFFICE USE ONLY	
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DEPENDENT CARE (child with a disability, dependent adult, elder care)

The Living Donor Support Program may reimburse dependent care expenses that would normally be performed by the living donor that is still required but due to the living donation process cannot be performed by the living donor. This is not to include already existing dependent care. There is a specific childcare form as their rates and reimbursement vary. Please make sure you select the appropriate form.

New York State-Living Donor Support Program
CHILD WITH A DISABILITY, DEPENDENT ADULT, ELDER CARE Reimbursement Form

Name of individual(s) receiving care	Date of Birth
Dependent care provider(s) name	**Provider relationship to child(ren)**

The Living Donor Support Program has set maximum rates of reimbursement for Child with a Disability, Dependent Adult, and/or Elder care.

Please indicate the date (mm/dd/yyyy) **and number of hours that dependent adult/elder care was provided on that day:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:

If applying for care reimbursement for a child with a disability or dependent adult include documentation of qualifying diagnoses by a provider with the appropriate credentials to make such diagnosis and documentation.

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AFTER READING THE STATEMENTS BELOW PLEASE SIGN AND DATE YOUR DESIGNATED SECTION

I attest that I have at least one dependent adult or elder who relies on me for care, and through the living donation process I have had to pay for care that I do not normally pay for. I understand the Living Donor Support Program will not pay for any care my dependents already receive, like care while I am usually at work.

Living Donor Signature: _____ **Date:** _____

I attest that the information provided on this form is accurate and that dependent adult/elder care was performed by myself for the dates and hours recorded.

Provider Signature: _____ **Date:** _____

CERTIFICATION	
I hereby certify that the above is just, true and correct, and that the amounts claimed were necessary and incurred during the process of living donation.	
Signature:	**Date:**

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LIVING DONOR TRAVEL EXPENSES (lodging, transportation, meals)

General Services Administration (GSA) rates are utilized in setting reasonable reimbursement for travel expenses. Reimbursement will be provided in accordance with the GSA rate for the area and year in which the organ donation takes place. Please note that the GSA rate is the maximum the program can reimburse, but when receipts indicate costs less that the GSA rate the donor will be reimburse at that amount. There are specified sections for lodging, meals and transportation. Current GSA rates can be found at www.gsa.gov/travel. Fill out the areas of travel for which you are requesting reimbursement. Each section will provide guidance regarding the additional receipts that will need to be attached.

LODGING

Please indicate below the date(s) and phase(s) of the living donor process for which you are seeking overnight lodging expense reimbursement. Attach all receipts related to lodging expenses

***Note:** To qualify for reimbursement of lodging expenses the living donor must live 75 miles one-way away from the transplant center as determined by program.

Hotel	Evaluation	Surgery and Recovery	Follow-up
	to	to	to
	to	to	to
	to	to	to

MEALS

Please indicate below the date(s) and phase(s) of the living donor process for which you are seeking meal expense reimbursement. Per program policy, meals can only be reimbursed when lodging is required by the living donor. Meal receipts will not be required.

Meals	Evaluation	Surgery and Recovery	Follow-up
	to	to	to
	to	to	to
	to	to	to

TRANSPORTATION

When completing this section, under starting and ending location, please indicate a description of the location as well as the address. A description could be a hotel, home, transplant center, etc. Complete for each trip (do not include round trip). See example below. Please attach any tickets, receipts, or proofs of travel.

Date	Mode of Transportation	Miles	Starting Location	Ending Location
EXAMPLE 01/01/2025	Personal car	150	Home 75 Something St Anywhere, NY 12345	Transplant Center Transplant Center St New York, NY 12345

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OTHER TRAVEL EXPENSES

List other travel related expenses you incurred that are directly related to your living donation process for which you are requesting reimbursement. Please attach all receipts and proofs of incurred expenses. Other expenses may include things like parking, rideshares and tolls.

Dates	Description of Expense

CERTIFICATION	
I hereby certify that the above is just, true and correct, and that the amounts claimed were necessary and incurred during the process of living donation.	
Signature:	**Date:**

FOR AGENCY USE ONLY		
Expense Report Number:	**Travel Authorization Code:**	
Entered by:		**Date:**

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SUPPORT PERSON TRAVEL EXPENSES

New York State-Living Donor Support Program can pay for one support person at a time per trip to the transplant center. A support person is reimbursed at a flat daily rate of $100, for up to 20 days total through all phases of the living donation process.

SUPPORT PERSON INFORMATION

Support Person's First Name	Last Name	Relationship to donor

Please indicate how many days your support person accompanied you and the dates of they provide support.

Number of days of support: _____ **Date**(s): _____ to _____

AFTER READING THE STATEMENTS BELOW PLEASE SIGN AND DATE YOUR DESIGNATED SECTION	
I attest that the support person identified physically accompanied me to the transplant center for the dates provided.	
Living Donor's Signature:	**Date:**
I attest that I physically accompanied the living donor to the transplant center and incurred personal expenses for the dates provided.	
Support Person's Signature:	**Date:**

CERTIFICATION	
I hereby certify that the above is just, true and correct, and that the amounts claimed were necessary and incurred during the process of living donation.	
Signature:	**Date:**

FOR AGENCY USE ONLY		
Expense Report Number:	**Travel Authorization Code:**	
Entered by:		**Date:**

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WAGE REIMBURSEMENT

To apply for wage reimbursement, you must have already submitted the required pay stubs, W-2/1099 and employer verification form. You are required to utilize any third-party payors that are available to you prior to making any requests to the Living Donor Support Program. Some examples include short term disability or an employer program that offers time off outside of your standard accruals.

The Living Donor Support Program can reimburse lost wages up to a total of 4 weeks, unless there are special circumstances determined by your medical provider, such as the donor having a physically demanding job. With special circumstances documented, the program can reimburse the living donor's lost wages for up to a total of 8 weeks. Please attach medical provider documentation indicating what special circumstances require being out of work for greater than 4 weeks. Program policy limits reimbursement of lost wages to 2 days for the evaluation phase and 1 day of lost wages per office visit during the follow-up phase of the process.

NEW YORK STATE-LIVING DONOR SUPPORT PROGRAM

Wage Reimbursement Form

Please indicate what third-party payors are available to you. This may be through employer benefits, recipient insurance or other sources: ______________________________

Have you sought reimbursement from these sources? ______________________________

Have you received reimbursement from these sources? ______________________________

If so, please indicate what have you received reimbursement for, and the amounts received?

*When utilizing any third-party payors please attach documentation to this reimbursement request. Documentation should include a clear description of the payor source and proof of reimbursement. The program may request further documentation if what's provided is not clear, potentially extending the wait time for Living Donor Support Program reimbursement.

Time Out of Work

1. **How long have you been out of work?** ______________________
2. **How long do you expect to be out of work?** ______________________
3. **Do you have documentation that your job qualifies for wage reimbursement of up to 8 weeks based on the definition of special consideration?** ______________________

Please indicate all dates (mm/dd/yyyy) **and work hours that you are seeking reimbursement for:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:
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Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:	Date: No. Hours:

Total hours for this request: ______________

OFFICE USE ONLY	
Application #:	**Applicant #:**

CERTIFICATION	
I hereby certify that the above is just, true and correct, and that the amounts claimed were necessary and incurred during the process of living donation.	
Signature:	**Date:**

FOR AGENCY USE ONLY		
Expense Report Number:	**Travel Authorization Code:**	
Entered by:		**Date:**

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MEDICAL EXPENSES

Attachment of receipts/denials for medical expenses not covered by health insurance or third-party payors will be needed along with this section filled out.

MEDICAL EXPENSES DIRECTLY RELATED TO ORGAN DONATION	AMOUNT CLAIMING
Unpaid/Unreimbursed Prescription Medications for Organ Donation (including over the counter prescribed medications)	
Other Unpaid/Unreimbursed Medical Costs (please provide details for unpaid/unreimbursed medical costs below)	
TOTAL MEDICATION AND MEDICAL EXPENSE COSTS CLAIMING:	$ 0.00

CERTIFICATION

I hereby certify that the above account and attached schedules are just, true and correct, that no part thereof has been paid, except as stated therein, and that the balance therein stated is actually due and owing, and that the amounts claimed were necessary an incurred in the performance of my official duties.

Signature:	**Date:**

FOR AGENCY USE ONLY		
Expense Report Number:	**Travel Authorization Code:**	
Entered by:		**Date:**