FINANCIAL HARDSHIP WAIVER WORKSHEET – 2024

IMPORTANT: ***Skip this page if your household income is equal to or below the NLDAC eligibility guidelines.***

NLDAC Eligibility Guidelines 350% HHS Federal Poverty Guidelines (FPG) 2024			
Household size	**48 Contiguous states and D.C.**	**Alaska**	**Hawaii**
1	$52,710	$65,835	$60,585
2	$71,540	$89,390	$82,250
3	$90,370	$112,945	$103,915
4	$109,200	$136,500	$125,580
5	$128,030	$160,055	$147,245
6	$146,860	$183,610	$168,910
7	$165,690	$207,165	$190,575
8	$184,520	$230,720	$212,240

Recipients: According to federal law, NLDAC cannot pay for a donor's travel expenses, lost wages, or dependent care expenses if the recipient can pay those costs. If your household income is above the NLDAC guidelines but you cannot support the donor, you can request NLDAC reconsider your ability to pay by completing this worksheet, which is a financial hardship waiver request. The financial hardship waiver process requires evaluation by the transplant professional, NLDAC and the Health Resources and Services Administration using fact-specific analysis of information captured in the form below. Your allowable out-of-pocket expenses must bring your income within the income guidelines for the application to be approved. For example, if your income is $5,000 above the NLDAC eligibility guidelines, you will need to demonstrate $5,000 in allowable annual expenses.

Please list monthly or one-time out-of-pocket expenses for ***your entire household****. NLDAC will calculate annual expenses based on the information provided in the worksheet.* ***Regular living expenses (like rent, utilities, etc.) should not be included.*** *If you have questions, call NLDAC toll free at (888) 870-5002.*

First name:	Last name:
Phone:	*(NLDAC staff may call you to clarify information on this worksheet.)*

1.	$	Monthly out-of-pocket **medical insurance** premiums (medical, dental, vision)
2.	$	Monthly out-of-pocket **pharmacy** co-pays **before transplant**
3.	$	Monthly out-of-pocket **pharmacy** co-pays **after transplant** *(Estimated by transplant professional)*
4.	$	Monthly out-of-pocket **physician** co-pays
5.	$	Monthly out-of-pocket **lab or other medical** co-pays **not listed above**
6.	$	Total hospital/medical bills owed **not covered by insurance** *(not monthly)*
7.	$	Loss of income due to surgery (excluding paid time off/disability pay) - describe in ***Comments**
8.	*# miles*	Monthly round trip **mileage** for medical appointments (pre-transplant)
9.		How will you travel to the transplant center for your surgery? Air ☐ Car ☐ Bus ☐ Train ☐
10.	*# miles*	If driving, how many **miles** round trip to the transplant center?
11.	*yes/no*	Will you need to stay in a hotel near the transplant center after your transplant surgery?
12.	*# nights*	If you will stay in a hotel, how many nights will you stay?
13.	*# trips*	In the first 3 months after your transplant, how many trips (estimate) will you make to the hospital?
14.	$	Monthly dependent care for family member not living in the household (ex. child support) - describe in ***Comments**
15.	$	Other expenses - describe in ***Comments**

If loss of income, monthly dependent care for a family member not living in household, or other allowable expenses are noted above, please describe those expenses here. You may attach an additional page if desired.

***Comments:**