Trillium Gift of Life Network
157 Adelaide Street West, Box 606
Toronto, Ontario M5H 4E7
Ph: 416-619-2342 or 1-888-977-3563 *(1-888-9PRELOD)*
Email: PRELOD@giftoflife.on.ca

Program for Reimbursing Expenses of Living Organ Donors - PRELOD

Application Form V3

I, the undersigned, understand that in making application to Trillium Gift of Life Network for expense reimbursement, I am required to provide certain information to the Network including:

● SECTION A: Living Organ Donor Applicant Information

1 Date: ______________________________

2 Name: ______________________________ 3 Gender: ☐ M ☐ F

4 Date of Birth: ______________ 5 Home phone: ____________

6 Email: ________________ Do you prefer correspondence via email: ☐ Yes ☐ No

7 Home Address: ____

8 City: ________________ 9 Province: ________________ 10 Country: ________________

11 Postal Code: ____________________ 12 Health Card Number: __________________

13 Passport Number, if from out of country: ____

14 Transplant Hospital: _________________________ 15 ☐ Kidney ☐ Liver

16 Are you eligible to receive funding from the Northern Health Travel Grant or any other sources?

☐ Yes ☐ No

17 If yes, have you applied to the Northern Health Travel Grant?

☐ Yes ☐ No

18 Have you ever made a claim to PRELOD before?

☐ Yes ☐ No

19 Will you be applying for PRELOD Loss of Income Subsidy?

☐ Yes ☐ No

If yes, are the ***Income and Benefit Verification Form*** and the ***Loss of Income Certificate*** attached?

☐ Yes ☐ No

I, ____,

the undersigned, have to the best of my knowledge, provided accurate and complete information.

I understand that the personal information provided in this application will be used only for the purposes of establishing my eligibility for expense reimbursement from Trillium Gift of Life Network. I further understand that TGLN may compile statistical information to report on their expense reimbursement program or for demographic purposes; no identifying personal information will be used for such reporting purposes. If you have concerns about how TGLN manages your personal information please see www.giftoflife.on.ca or call the Privacy Officer at 416-363-4001 or 1-800-263-2833.

____ __________________________

Signature of applicant Date

✱ *Optional:*

The following information is being collected for statistical purposes only. No identifying information will be linked with your responses. Your responses will be kept confidential.

Ethnic Background ______________________________________

Are you related to the intended organ recipient?

☐ Related ☐ Unrelated ☐ I am donating anonymously

Are you participating in paired exchange donation?

☐ Yes ☐ No

Section B: Living Donor Expense Claim Form

1 Name: ______________________________ 2 Date: ______________________

3 Date of Birth: ________________________ 4 Phone: ______________________

Expense Itemization: Original receipts are required for reimbursement of expenses

5 **Expense Category**	6 **Details**		7 **Type of Visit** A= assessment S= immediate post surgery	8 **Eligibility**
9 **Travel** *Maximum reimbursement is $1,500 for all travel*	10 **Mileage: _______ km @ $0.41/km =** **** Attach mileage record (see Section C)***			*If applicant lives at least 60km **one-way** from transplant hospital.*
	11 **Shuttle/ Taxi to/from airport ☐** **Date:**	**$**		*If applicant lives at least 100km **one-way** from transplant hospital.*
	Date:	**$**		
	Bus ☐	**$**		
	Date:			
	Air ☐	**$**		
	Date:			
	Train ☐	**$**		
	Date:			
		Total $:		
12 **Parking or Public Transit** *Maximum reimbursement is $140. Daily maximum is $20.*	**Date**	**Amount**		
		$		
		$		
		$		
		$		
		$		
		Total $:		
13 **Meals** *Maximum reimbursement is $200. Daily maximum is $40.*	**Date**	**Amount**		*If applicant lives at least 100km **one-way** from transplant hospital.*
		$		
		$		
		$		
		$		
		$		
		Total $:		

Expense Category	Details		Type of Visit A= assessment S= immediate post surgery	Eligibility
14 **Meal Allowance** *Maximum reimbursement is $150. Daily maximum is $30.*	**Date**	**Amount**		*If applicant lives at least 100km **one-way** from transplant hospital. In lieu of meals and accommodation, when applicant stays with family or friends.* *Note: No receipt is required.*
		$		
		$		
		$		
		$		
		$		
		Total $:		
15 **Accommodation** *Maximum reimbursement is $625. Daily maximum is $125 per night.*	**Date**	**Amount**		*If applicant lives at least 100km **one-way** from transplant hospital.*
		$		
		$		
		$		
		$		
		$		
		Total $:		
16 **Other**	**Date**	**Amount**		*On an exceptional basis only for childcare, in lieu of loss of income for a non-working parent.*
		$		
		$		
		$		
		$		
		$		
		Total $:		

For TGLN Use Only:

Date received: ____________________

ID Code: ____________________

Total Expenses: $ ____________________

Section C: Living Donor Expense Claim Form

1 Name: ______________________________ 2 Date: ______________________________

3 Date of Birth: ________________ 4 Phone: ______________________________

5 **Mileage Tracking** *If applicant lives at least 60km **one-way** from transplant hospital.*		
6 **Date**	7 **Details/Purpose of Trip**	8 **km**

For TGLN Use Only:

Date received: ________________

ID Code: ________________

Total Expenses: $ ________________