Trillium Gift of Life Network | Réseau Trillium pour le don de vie

Transplant Patient Expense Reimbursement (TPER) Program

APPLICATION FORM

The Transplant Patient Expense Reimbursement (TPER) Program helps in alleviating the financial burden on patients waiting for heart, heart-lung, or lung transplantation who, as a requirement of an Ontario transplant program, must temporarily relocate to the proximity of the transplant hospital to be waitlisted and/or to obtain post-transplant surgery discharge care.

Avoid delays – Ensure all required forms and supporting documentation are submitted. Please ensure you indicate the payee name and mailing address correctly on the application form for your payment to be processed (if your application is approved).

Eligibility Criteria for the Transplant Patient Reimbursement Program – Patient must satisfy all the following:

1. Must be a patient waiting for heart, heart-lung, or lung transplantation. Small bowel transplant patients may be considered for eligibility as exceptional cases.
2. Must reside a minimum of 2.5 hours driving distance from a transplant hospital and for greater certainty, where the transplant hospital policy requires the patient to relocate as a prerequisite for placement on the transplant hospital's waiting list and/or for post-surgery discharge assessment.
3. Must be an Ontario resident and be insured by the Ontario Health Insurance Plan (OHIP).
4. Must confirm that accommodation costs are not covered by another program/organization and that all other sources of funding specific to accommodation expenses have been exhausted.
5. Must be referred by a transplant physician, as specified on the Support for Relocation Form, before the patient relocates.

Eligibility for Accommodation Reimbursement (if your application is approved) – A patient must meet all of the following criteria in order to be eligible for the accommodation reimbursement**:**

1. The patient meets the TPER Program eligibility criteria set out above.
2. The patient has temporarily relocated or will imminently relocate temporarily to the proximity of the transplant hospital in order to meet the transplant hospital requirement as set out above: #2.
3. The patient has submitted original or copies of detailed accommodation receipts (e.g. official hotel or lodging receipts) to prove a lodging expense was incurred. For patients under 18 years of age, an accommodation receipt can be in the name of the parent/guardian and
    a. in the case of determining payment for accommodation expenses <u>prior</u> to the transplant surgery, the transplant hospital has confirmed with Trillium Gift of Life Network that the applicant is listed or will be listed upon imminent temporary relocation to the proximity of the transplant hospital for placement on the heart, heart-lung, or lung waiting list according to the criteria of the transplant hospital or;
    b. in the case of determining payment for accommodation expenses <u>after</u> the transplant surgery and post discharge, the transplant hospital has confirmed with Trillium Gift of Life Network that the applicant requires follow-up care related to transplantation at the transplant hospital.

Please note:

- Your transplant program must submit a Support for Relocation Form to TGLN close to the patient's wait list date for approval.

Ontario

Trillium Gift of Life Network / Réseau Trillium pour le don de vie

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APPLICATION FORM

Please send completed form to:
ATTN: TPER Administrator
Trillium Gift of Life Network
157 Adelaide Street West, #606
Toronto, Ontario M5H 4E7
 	
For more information:
Telephone: 416-619-2342 or 1-888-977-3563
Fax: 416-363-4002
Email: mailto:TPER@giftoflife.on.ca
	The applicant must complete and submit:
	• Application Form
	• Supporting Documents
	  • Lease or Rental Agreement
	  • Proof of Payment
	
	The Transplant Coordinator must complete and submit:
	• Support for Relocation Form
	
	Please speak with your transplant coordinator or social worker about other forms and documentation that may be required.

SECTION A: APPLICANT INFORMATION

Transplant Hospital Information

Transplant Hospital:

Transplant Type: ☐ Heart ☐ Lung ☐ Heart-Lung

Patient Information

First Name: Middle Initial: Last Name:

Gender: ☐ M ☐ F Date of Birth (MM/DD/YYYY): OHIP Number:

Home Address:

City: Province: Postal Code:

Home Telephone: Mobile Telephone: Email Address:

Do you prefer correspondence via email? ☐ Yes ☐ No

Parent or Caregiver Contact Information

If a substitute decision maker or power of attorney (for property) is listed here, please include documentation supporting status with this application. ☐ **Check here to indicate the payment should be payable to the parent or guardian.**

First Name: Last Name:

Relationship:

Home Telephone: Mobile Telephone: Email Address:

SECTION B: FUNDING FROM OTHER PROGRAMS

Please complete the table below to disclose funding that you have received from other programs/activities (e.g. government programs or registered charities) to directly or partially cover accommodation expenses related to relocation for transplantation purposes. ☐ **I am not receiving funding from other programs.**

Program	Date Received	Amount ($)	Comments/Notes

Ontario

SECTION C: LOCAL ACCOMMODATION EXPENSE INFORMATION

If at any time, the details of your local accommodations (e.g. address, rental costs, etc.) change, you are required to notify the TPER Administrator immediately at 416-619-2342 / 1-888-977-3563.

Address of Relocation

Address:

City: Province: Postal Code:

Local Telephone:

Lease/ Rental Details

Rental or Property Management Company:

Address:

City: Province: Postal Code:

Property Manager or Landlord Full Name: Contact Telephone:

Term of Lease/ Rental Agreement

Please provide documentation to support your temporary relocation lease/rental agreement. Original or copies of detailed accommodation receipts must be provided for a reimbursement to be processed.

Start Date:

End Date:

Monthly Lease/ Rental Cost:

APPLICATION FORM

PAYMENT SCHEDULE:

Please complete the fields under "To Be Completed by the Applicant" as fully as you can. Any additional information relating to the consideration of reimbursement in the subsequent months can be sent to TGLN at a later date.

Patient's Full Name: _____

To Be Completed by the Applicant				For TPER Administrator Use TGLN#_____		
Month	**Date**	**Lease/Rental Cost**	**Receipt Enclosed (Y/N)**	**Proof of Payment Provided**	**Qualified Reimbursement ($)**	**Cheque # Issued**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
TOTAL						

SECTION D: CERTIFICATION STATEMENT

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 (TGLN). The information provided will be subject to processing by Workday, a third-party service provider, in a jurisdiction outside of Canada. Workday is compliant with internationally recognized standards of privacy protection and is subject to the General Data Protection Regulation (GDRP) of the European commission. 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 1-800-263-2833. I also agree to notify TGLN of any changes that may affect my eligibility or continued eligibility for receiving reimbursement through this program.

APPLICATION FORM

Please send my reimbursement cheques to my (check one): ☐ Home Address ☐ Temporary Address

_____

Print full name of Applicant or Parent/Caregiver

_____ _____

Signature of Applicant or Parent/Caregiver | Date (MM/DD/YYYY)