



# Transplant Patient Expense Reimbursement (TPER) Program Support for Relocation Form

## TO BE COMPLETED AND SIGNED BY THE PATIENT'S TRANSPLANT COORDINATOR

<p><b>Please send the completed form to:</b> Attention: TPER Administrator Trillium Gift of Life Network 157 Adelaide Street West, #606 Toronto, Ontario M5H 4E7</p> <p><b>For more information:</b> Telephone: 416-619-2342 or 1-888-977-3563 Fax: 416-363-4002 Email: <a href="mailto:TPER@giftoflife.on.ca">TPER@giftoflife.on.ca</a></p>	<p><b>The Transplant Coordinator must complete and submit:</b></p> <ul style="list-style-type: none"> <li>• Support for Relocation Form</li> </ul> <p><b>The applicant must complete and submit:</b></p> <ul style="list-style-type: none"> <li>• Application Form</li> <li>• Supporting Documents (if applicable)             <ul style="list-style-type: none"> <li>• Lease or Rental Agreement</li> <li>• Proof of Payment</li> <li>• Void Cheque or Letter from Financial Institution</li> </ul> </li> </ul> <p>Please speak with your patient to check that all necessary documentation is completed and submitted.</p>
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### Patient Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ OHIP Number: \_\_\_\_\_

\_\_\_\_\_ who is covered by the Ontario Health Insurance Plan, requires  
*Patient's Full Name*

a \_\_\_\_\_ transplant at the \_\_\_\_\_  
*Specify: Heart, Lung, Small bowel, or Heart and Lung Transplant Hospital*

He/she is required to relocate within proximity of the transplant hospital to be listed for transplantation and/or for post-transplant assessment, as required by our program's policy. I am writing this letter in support of relocation to indicate that the patient, as mentioned above, was asked to relocate to access services related to transplantation.

The following is true about the patient (check all that apply):

- The patient meets the eligibility criteria (see the Application Form) for the TPER Program.
- The patient has provided evidence to support that he/she has relocated.
- The patient is currently on the waitlist for transplantation.
- The patient was asked by the transplant physician to relocate for the purpose of (check all that apply):
  - Pre-transplant
  - Post-transplant, for a period of \_\_\_\_\_ months.

If the patient does not meet the eligibility criteria, please state the reason for relocation below (check all that apply):

- No access to the required healthcare services close to the patient's home address
- Other (please specify): \_\_\_\_\_

The patient provided evidence in support of relocation on \_\_\_\_\_  
Date (MM/DD/YYYY)

If you have any further questions, please contact:

<b>Transplant Coordinator's Full Name</b>	<b>Telephone:</b>
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Sincerely,

\_\_\_\_\_  
Signature of Transplant Coordinator

\_\_\_\_\_  
Date (MM/DD/YYYY)

FOR TPER ADMINISTRATOR USE		
TGLN ID#:	Wait-List Date:	Transplant Date: