The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

Tel: 617-624-6000
Fax: 617-624-5206
www.mass.gov/dph

Massachusetts Organ Transplant Fund
Application Form

Date of Application*:

Name of Applicant: Date of Birth:

Address:

Phone Number: Email:

Mailing Address (if different from above):

Name of Transplant Center:

Date of Transplant:

Type of Transplant:

Name of Health Insurance (attach copy of Schedule HC from most recent Massachusetts income tax return):

Adjusted Gross Family Income (attach copy of most recent Massachusetts income tax return):

I, _____, attest that the information above is accurate to the best of my knowledge.

_____ _____ _____ _____
Signature of Applicant Date Signature of Witness Date

*Application must be submitted annually to determine continued medical and financial eligibility

Applicant must provide the following required attachments:

- A signed letter from the established transplant center, or current physician overseeing direct care related to the transplant, providing diagnosis, patient status and patient's current level of activity
- Copy of most recent Massachusetts and Federal Income Tax Returns and Schedule HC (health insurance verification form)

Send completed application form along with required attachments to:

Lea Susan Ojamaa, Director
Division of Prevention and Wellness
250 Washington Street, 4th Floor
Boston, MA 02108