

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

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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.

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\*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**