



2025 DONOR APPLICATION WORKSHEET LIVING ORGAN DONATION REIMBURSEMENT PROGRAM

This is the donor's part of an application for reimbursement of expenses from the National Living Donor Assistance Center (NLDAC). Donors can apply for help with travel, lost wages, and dependent care expenses. If you are considering donating to help a specific person, that person will need to complete the recipient application worksheet and provide documentation of their household income to the transplant center.

Instructions

1. Complete this application worksheet, answering all the questions. If there is a type of reimbursement you do not want, you can skip that page.
2. Attach proof of your **household** income. Your household includes you, your spouse if you are married, and your dependents (like children under 22). We use this to categorize applications based on financial need. You can use any of these:
 - Federal income tax return
 - IRS Form W-2 or 1099
 - Pay stubs
 - Social Security benefits letter
 - Proof of eligibility for Medicaid, SNAP or WIC
3. For reimbursement of lost wages, also attach your 2 most recent pay stubs. If you do not get pay stubs, you can use Schedule C, IRS Form 1099 or an earnings statement from a company you do contract work for. We use this to calculate your lost wages.
4. For reimbursement of lost wages or dependent care, complete IRS Form W-9 on page 7. We use this to create a tax form for you.
5. Give the completed packet to your social worker or another transplant professional, who will submit the application for you. **Do not send it directly to NLDAC.**

Need help?

If you have questions, call NLDAC at 888-870-5002. We're here to help 9am – 5pm Eastern Time Monday through Friday, except federal holidays.

Deadlines

The application must be approved before the donation surgery, and only expenses incurred after approval will be reimbursed. Allow 10-15 business days for processing. Faster review in 1-2 business days is available for urgent liver donations.



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Donor Information

What type(s) of reimbursement are you applying for?

- Travel expenses
 Lost wages
 Dependent care

First name	Last name	Date of birth	Social Security number

Important: full name must match the name on your tax return.

Sex	Race	Ethnicity	Marital status	Education
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Grade school <input type="checkbox"/> High school/GED <input type="checkbox"/> Post high school/tech or trade <input type="checkbox"/> Some college <input type="checkbox"/> 4-year college <input type="checkbox"/> Post college/professional

Employment status	Organ	Eligibility questions	
<input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> On disability <input type="checkbox"/> Retired <input type="checkbox"/> Homemaker/caretaker <input type="checkbox"/> Student <input type="checkbox"/> Unemployed	<input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Uterus	Are you a US citizen or lawfully present resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you signed the attestation form on page 6? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Program impact questions	
		The NLDAC program will make it possible for me to be an organ donor. <input type="checkbox"/> True <input type="checkbox"/> False	Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to transplant candidate (recipient)
I am the _____ of the recipient
<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Spouse <input type="checkbox"/> Other
If other, please specify: _____
Type of relationship: <input type="checkbox"/> Blood related <input type="checkbox"/> Non-blood related (by marriage, adoption, etc.) <input type="checkbox"/> Unrelated

Primary residence address
Street address: _____ City: _____ State: _____ Zip code: _____
Location: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural If rural, what is the population? _____
Phone #: _____ Alt. phone #: _____ Email: _____
Mailing address (if different)
Street address: _____ City: _____ State: _____ Zip code: _____

Household information - Include yourself, your spouse if you are married, and dependents like children
Yearly household income: \$ _____ Number of people in household: _____
What document(s) will you attach to verify your household income?
<input type="checkbox"/> Federal income tax return – use adjusted gross income <input type="checkbox"/> Social Security benefits letter <input type="checkbox"/> Pay stubs – use gross income <input type="checkbox"/> Eligibility for government assistance (HUD, WIC, SNAP) <input type="checkbox"/> W2 – use box 1 <input type="checkbox"/> Eligibility for Medicaid <input type="checkbox"/> Other document (unemployment benefits, etc.)

How should we address you? You can tell us your preferred name, language, etc.:



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Request For Reimbursement of Lost Wages (optional)

- I attest that the information I will give here is true and complete to the best of my knowledge.
- I attest that I am currently employed and expect to lose wages when I take time off from work for my recovery after the donation surgery, and/or for evaluation and follow-up appointments. I understand I must notify NLDAC if I stop working and submit new pay stubs if my wages change.

1. How often are you paid?
 - Weekly
 - Every 2 weeks
 - Twice a month
 - Monthly
 - Irregularly/other. Please explain: _____

2. Do you plan to use short-term disability or paid time off (PTO) to cover some of your time off work related to your organ donation?
 - No
 - Yes. Provide as much detail as you can: _____

Note: NLDAC does not require you to exhaust your PTO, but if you have PTO and want to save it for later, you will need to ask your employer if they allow that.

3. For which trips would you like NLDAC to reimburse your lost wages? Only check trips that are in the future.
 - Evaluation (up to 3 days)
 - Surgery and recovery (up to 4 weeks)
 - Follow-up trips (up to 2 weeks)

4. How much of the maximum NLDAC reimbursement (\$6,000 to cover all expenses) would you like to dedicate to lost wages? \$_____. The rest can go toward your travel or dependent care costs.

5. Complete and sign IRS Form W-9 on page 7.

6. If you are an employee, attach your **two most recent pay stubs**. If you are self-employed or an independent contractor, attach Schedule C, IRS Form 1099, or an earnings statement generated by a company you do contract work for.

Other comments (optional): _____



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Request For Reimbursement of Dependent Care Expenses (optional)

- I attest that the information I will give here is true and complete to the best of my knowledge.
I attest that I have at least one dependent (child, disabled adult or elder) who relies on me for care, and by donating an organ I will have to pay for child-care or adult/elder-care that I do not normally pay for. I understand NLDAC will not pay for any care my dependents already receive, like daycare while I am usually at work.

- 1. How many children (ages 0 – 17) will need care because of your donation?
2. On which trips would you like NLDAC to reimburse your childcare expenses?
3. How many disabled adults (ages 18 – 64) or elders (age 65+) will need care because of your donation?
4. On which trips would you like NLDAC to reimburse you for care of a disabled adult or elder?
5. List the children, disabled adults, or elders for whom you will need to arrange alternate care:

Table with 3 columns: Name, Relationship (this person is my...), Age

- 6. When will your dependents need alternate care because of your donation?
7. How much of the NLDAC maximum (\$6,000 to cover all expenses) would you like to dedicate to dependent care?
8. Complete and sign IRS Form W-9 on page 7.



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Request For Reimbursement of Travel Expenses (optional)

Accompanying person(s)

NLDAC can pay for **one** accompanying person to go on two trips or **two** people to go on one trip.

First accompanying person <input type="checkbox"/> Check here if same address as donor			Second accompanying person <input type="checkbox"/> Check here if same address as donor		
First name:	Last name:		First name:	Last name:	
DOB:	Phone:		DOB:	Phone:	
Street address:			Street address:		
City:	State:	Zip:	City:	State:	Zip:
Trip(s): <input type="checkbox"/> Evaluation only <input type="checkbox"/> Evaluation & surgery <input type="checkbox"/> Evaluation & follow-up	<input type="checkbox"/> Surgery only <input type="checkbox"/> Surgery & follow-up <input type="checkbox"/> Follow-up only		Trip(s): <input type="checkbox"/> Evaluation only <input type="checkbox"/> Evaluation & surgery <input type="checkbox"/> Evaluation & follow-up	<input type="checkbox"/> Surgery only <input type="checkbox"/> Surgery & follow-up <input type="checkbox"/> Follow-up only	

Estimated travel plans

	EVALUATION	SURGERY	FOLLOW-UP
HOTEL	Up to 2 nights	Up to 14 nights	Up to 1 night
How many hotel nights will the donor need?			
If a separate room is needed, how many hotel nights will the accompanying person(s) need?			
MEALS			
How many days will the donor and accompanying person be away from home?			
TRANSPORTATION			
How will the donor travel to the transplant center? <i>Car, air, bus, train</i>			
If driving, how many miles is the donor's round trip ?			
How will the accompanying person(s) travel to the transplant center? <i>Car, air, bus, train</i>			
If the accompanying person will drive separately, how many miles is their round trip ?			
Estimate cost of parking per day			
How many days will you pay for parking?			
Estimate tolls (if any)			
Estimate cost of taxi/shuttle/Uber/rental car if you plan to use them			
Do you need a rental car?			
Other information (optional):			



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Donor Attestation Form

Transplant professionals: file this page in the donor’s medical record.

Donors: print your name in the blank at the top, read the statements, then sign your name at the bottom.

I, _____, as a living organ donor candidate, have truthfully and completely provided all the information requested in this application for reimbursement of expenses related to my potential donation.

- I understand that the donor travel card can only be used for transportation, lodging and meals during my evaluation, donation and follow-up trips. I will **not** use it to buy anything else, including but not limited to alcohol, tobacco, illegal drugs or firearms.
- The transplant center personnel have informed me of what constitutes “valuable consideration” and to the best of my understanding, I am in full compliance with Section 301 of NOTA (42 U.S.C. §274e), which stipulates, in part, that it shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.
- My decision to undergo live organ donation was not motivated by the exchange of any valuable consideration.
- I do not have any other information indicating that valuable consideration is being exchanged in connection with this donation procedure.
- I understand that NLDAC, under Federal law, cannot provide reimbursement to any living organ donor for travel and other qualifying expenses if the donor can receive reimbursement for those expenses from any of the following sources: (1) Any state compensation program, an insurance policy, or a Federal or State health benefits program; (2) an entity that provides health services on a prepaid basis; or (3) the recipient of the organ.
- I give permission for the transplant center to share my information with the National Living Donor Assistance Center.
- I acknowledge that reimbursement may be subject to federal and/or state income tax reporting. I am responsible for contacting a qualified tax advisor to determine tax liability. Neither NLDAC nor other entities providing reimbursement are responsible for any tax consequences of the reimbursement program.
- I will not request reimbursement of expenses reimbursed in full by NLDAC from any other source (e.g. National Kidney Registry, Alliance for Paired Kidney Donation, Georgia Transplant Foundation, etc.).
- (Only for donors whose recipient is commercially insured by UnitedHealthcare) I give permission to NLDAC to provide the information in this application to other entities, including the recipient’s health insurer, for review and potential reimbursement for travel and other qualifying expenses. The health insurer will only use or disclose the information in accordance with the applicable law.

In signing this form, I declare, under penalty of perjury under the Federal and State laws, that all the information I have provided is true, correct and complete. I further understand that Federal and State law may provide for penalties of fine and/or imprisonment or denial of the requested reimbursement if I do not tell the truth when applying for assistance under the live donor reimbursement program or if I conceal or fail to disclose facts regarding the information supplied in the application process.

Donor’s signature: _____ Date: _____

Transplant center application filer’s signature: _____ Date: _____

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
requester. Do not
send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See <i>Specific Instructions</i> on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)	
	2	Business name/disregarded entity name, if different from above.	
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____ <input type="checkbox"/>	
	5	Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)
	6	City, state, and ZIP code	
	7	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number									
-				-					
or									
Employer identification number									
-									

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they