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

Transplant Patient Expense Reimbursement (TPER) Program

Support for Relocation Form

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

Please send the completed form to:
Attention: 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: TPER@giftoflife.on.ca

The Transplant Coordinator must complete and submit:
- Support for Relocation Form

The applicant must complete and submit:
- Application Form
- Supporting Documents (if applicable)
  - Lease or Rental Agreement
  - Proof of Payment
  - Void Cheque or Letter from Financial Institution

Please speak with your patient to check that all necessary documentation is completed and submitted.

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 _____
Heart, Lung, Heart-Lung, VAD (Ventricular Assistance Device), Small Bowel *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:

Transplant Coordinator's Full Name		**Telephone:**	

Sincerely,

_____ _____
Signature of Transplant Coordinator Date (MM/DD/YYYY)

FOR TPER ADMINISTRATOR USE

TGLN ID#: _____ Wait-List Date: _____ Transplant Date: _____

Ontario Health
Trillium Gift of Life Network