

Jake's Help From Heaven Medical Travel Application

Jake's Help From Heaven was founded in 2011 by Jake's parents, Brian and Heather Straughter. Jake Alexander Straughter earned his angel wings on December 8, 2010. Jake was born on May 4, 2006 a healthy, vibrant baby boy. He suffered a seizure at 8 months old and this began his very complicated medical journey. Through his short life, he battled epilepsy, liver disease, osteopenia, femur fractures, hip dislocation and more. He faced each hurdle with strength and courage and taught those around him how to persevere. Though Jake lived in Saratoga Springs, NY, the majority of his care took place in Boston, MA. With rare and severe illnesses, we understand the importance of seeking medical care from the best specialists at top hospitals.

This Medical Travel Application was created to assist children and families seeking the best possible medical care. Awards will be given to families who travel over 90 miles from home to seek medical care and/or treatment, but lack adequate financial resources for the cost of this travel.

All Jake's Help From Heaven applicants must live within 100 miles of Saratoga Springs.

Grants will be awarded up to \$2500. There is also a \$2500 cap per applicant per calendar year. Applicants can apply more than once but for not more than \$2500 per calendar year.

Grants will be reviewed by the Board of Directors four times per year and grants will be awarded following these meetings. Deadlines for each meeting are posted on our website at jakeshelpfromheaven.org

Please note that even if you are a REPEAT APPLICANT, you must fill out a MEDICAL TRAVEL APPLICATION in order to be reimbursed for your medical travel

TRAVEL APPLICATION GUIDELINES - Please complete all Sections

Section A- Personal Information

To be completed by patient or legal guardian. Please provide all personal contact information. Provide a brief description the medical treatment along with an explanation of why it is necessary to travel beyond 90 miles from your home. If necessary, attach a separate sheet with your explanation.

Section B-Medical Treatment/Services Information

List the name of the facility you will be traveling to and include the facility address and telephone number.

A post appointment letter or complete discharge notes from the treating doctor indicating reason(s) for treatment and treatment dates is required. Attach this letter as a part of your application.

Section C-Travel Information

Provide beginning and ending of travel date(s). Complete all expenses on the worksheet, including all totals. Please note the following:

- Mileage is compensated at .24/mile. GAS is not reimbursable – please do not submit gas receipts.
- If travel is via bus, train or airplane please submit receipts which indicate that tickets have been paid.
- Lodging is covered for the night of the appointment(s) as well as EITHER the night before OR after appointments. If the hospital stay is over an extended time period, we will cover the duration of the hospitalization. It is expected that lodging will be at a mid-scale hotel and will be reimbursed up to \$150/night.
- Meals are covered for day of appointment(s) as well as EITHER the day before OR after the appointment. Meals will only be reimbursed up to \$30/day. Alcohol not included. Copies of receipts must be sent in an organized fashion. Please photo copy no more than 4 receipts per page and arrange by day with the earliest day first.
- Tolls and parking costs are covered and will be reimbursed based on receipts.

Covered Expenses

- Air, train, bus fare or mileage between an applicant's residence and the facility where treatment is received.
- Cab fare, parking and tolls.
- Lodging/hotel room nights.
- If the patient receiving treatment is a minor and/ or is cognitively unable to travel without adult supervision/assistance, the fund will cover the expenses for an adult companion/parent as a part of the award.

Expenses Not Covered

- Entertainment (i.e. in-room movies, etc.)
- Personal hygiene items
- Alcoholic beverages
- Gasoline (costs for gasoline are included in the mileage reimbursement)
- Anything else not explicitly listed as "Covered Expenses".

Section D-Disclosure/Signature

Date and sign the application. Must be signed by primary care doctor and/or social worker as well.

Incomplete applications will result in a delay or denial.

Section A: Personal Information

Applicant:

Age:

Parent/Guardian (if applicable):

Address:

City:

State:

Zip:

Daytime phone #:

Evening phone #:

Email address:

Describe your medical condition and the treatment you are seeking. Include why it is necessary to travel 90 miles or more to seek treatment/services as well as where you will be treated and by whom. If follow-up care at this facility will be necessary please include when and why. Please use additional paper if necessary.

Section B: Medical Treatment/Services Information

Doctor/Facility:

Address:

City:

State:

Zip:

Telephone:

A post appointment letter or complete discharge notes from the treating doctor indicating reason(s) for treatment and treatment dates is required.

Section C: Travel Information

Travel Start Date:
Appointment Date:

Travel End Date:

Please fill out the attached expense form. Applications will not be reviewed if this sheet is not filled out.

Section E: Disclosure/Signature

I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge. I understand that what I submit to Jake's Help From Heaven is for the purpose of financial reimbursement to enable travel for medical treatment/services.

I understand that I may be required to provide additional evidence of submitted information and I give permission to Jake's Help From Heaven to contact the medical facility for verification purposes.

I agree to allow Jake's Help From Heaven to use my name in announcements and related publications.

Signature of Applicant or Parent/Guardian: _____

Printed name of Applicant or Parent/Guardian: _____

Date: _____

Signature of social worker or primary doctor: _____

Printed name of social worker or primary doctor: _____

Contact number: _____ Date: _____

Application Checklist:

Please make sure to include the following:

- Completed, signed application
- Medical letter from doctor on medical facility letterhead
- Completed expense worksheet
- All receipts for travel reimbursement

Jake's Help From Heaven Medical Travel Application
PLEASE FILL OUT THIS FORM COMPLETELY OR APPLICATION WILL NOT BE REVIEWED.

Applicant's Name							
	Date	Date	Date	Date	Date	Date	Date
Date (MM/DD/YY)							

	Place an "X" in the shaded columns to indicate that receipt is attached.										Total
Miles Traveled											
Mileage @ \$.24 Per Mile	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
Parking & Tolls	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
Other Transportation	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
Lodging	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
Meals up to \$30/day	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
Total Per Day	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

DOCTOR APPTS	DATE	LOCATION	FORM MUST BE SIGNED OR APPLICATION WILL NOT BE REVIEWED.	
			Parent Signature	Date
			Social Worker or Doctor Signature	Date

COMMENTS OR OTHER INFORMATION: