

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 and 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 date(s). Complete all necessary columns on the expense worksheet. Please note the following:

1. **MILEAGE** – Mileage is paid at .40 per mile. This rate is inclusive of all related transportation expenses. We do NOT reimburse for any parking or tolls. We do NOT reimburse for gas.
2. **LODGING** – Lodging is paid at the rate of up to \$150/night. Please submit lodging receipt for verification.
3. **MEALS** – Meals are reimbursed at the rate of \$50/day for the day OF appointments only, or the duration of an inpatient hospital stay. Receipts are NOT required

- If travel is via bus, train or airplane please submit receipts which indicate that tickets have been paid.

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 **REQUIRED**:

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 and 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

Please fill out the attached Expense Worksheet COMPLETELY. This includes totaling all appropriate columns.

Applications will not be reviewed if this sheet is not filled out.

Section D: 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
- Required receipts for travel reimbursement

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

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

| | | | | | | | | TOTAL |
|---------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| Mileage (.40/mile) | | | | | | | | |
| Other Transportation | \$ | \$ | \$ | \$ | \$ | \$ | \$ | |
| Lodging up to \$150/night | \$ | \$ | \$ | \$ | \$ | \$ | \$ | |
| Meals \$50/day per family | \$ | \$ | \$ | \$ | \$ | \$ | \$ | |
| Total Per Day | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - |

| DOCTOR APPTS | DATE | LOCATION | |
|--------------|------|----------|--|
| | | | FORM MUST BE SIGNED OR APPLICATION WILL NOT BE REVIEW |
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| | | | |
| | | | |
| | | | |
| | | | Parent Signature |
| | | | Social Worker or Doctor Signature |
| | | | |
| | | | |

COMMENTS OR OTHER INFORMATION:

