Jake's Help From Heaven LOCAL 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 LOCAL Medical Travel Application is intended for those who travel less than 90 miles for their medical care. This application is for medical care outside the scope of routine visits with a pediatrician or primary care physician. Reimbursement is provided only for mileage and only for care that relates specifically to the applicants' diagnosis.**

- **Grants will be awarded up to $2500 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**

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

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 of the medical treatment. 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 from the treating doctor indicating reason(s) for treatment and treatment date(s) is REQUIRED. Attach this letter as a part of your application.

Section C-Travel Information

- Provide the date and total mileage for each appointment on the worksheet provided. 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.

Section D-Disclosure/Signature

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

Incomplete applications will result in a delay or denial.

<u>Section A:</u> Personal Information

Applicant Name: **Age:**

Parent/Guardian (if applicable):

Address:

City: **State:**

Zip:

Phone Number #:

Email address REQUIRED:

Describe your medical condition and the treatment you are seeking. Include your current treatment plan and the frequency of your medical appointments.

Section B: Medical Treatment/Services Information

Doctor and Facility:

Address:

City: **State:** **Zip:**

Telephone:

A post appointment letter from the treating doctor indicating reason(s) for treatment and treatment date(s) 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 completed.

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 ApplicantParent/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 mileage worksheet

Jake's Help From Heaven Medical Travel Application EXPENSE WORKSHEET

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)								

							TOTAL
Mileage (.40/mile)								
Other Transportation	$	$	$	$	$	$	$	
Total Per Day	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

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

COMMENTS OR OTHER INFORMATION: