Jake's Help from Heaven Travel Application

Jake's Help from Heaven, founded in 2011, is a non-profit dedicated to supporting individuals with complex medical needs and disabilities resulting from congenital or childhood-onset diseases. Our primary objective is to improve the livelihoods of these persons as they confront the challenges of managing lifelong, debilitating illness.

Please read the following requirements carefully. Incomplete applications or those submitted in unacceptable formats will not be reviewed.

Grant Eligibility:

- Grants are limited to individuals living within 100 miles of Saratoga Springs, New York.
- Grants are restricted to individuals with complex medical needs and disabilities resulting from congenital or childhood-onset diseases. Applicants of all ages with lifelong, debilitating illnesses are welcome to apply.

Grant Criteria:

- A post-appointment letter or complete discharge notes from the treating doctor indicating reason(s) for treatment and the treatment dates are REQUIRED.
- Completed Expense Worksheet with all columns totaled. Applications will not be reviewed if the worksheet is not completed.
- Completion of the following application with the signature of pediatrician/primary care doctor or social worker.
- Receipts for reimbursement
- Applicants should submit their completed applications with all required documents at one time, and not in separate pieces.
- Electronic applications must be submitted in PDF format. We DO NOT accept jpegs or screenshots.
- There is a $2,500 cap per applicant per calendar year. Applicants may apply multiple times within a calendar year but are only eligible to be awarded a total of $2,500 within that year.
- Grants will be reviewed four times per year at the Board of Directors' quarterly meetings. Approved grants will be awarded approximately 2 weeks after each meeting. Application deadlines and meeting dates can be found on Jakeshelpfromheaven.org.

Section A: Personal Information

Applicant's Name: Age:

Parent/Guardian's Name:

Address:

City: State:

Zip:

Daytime phone #: Evening phone #:

Email address:

Contact information for the individual completing the application (if different from applicant/guardian):

Name: Relationship to Applicant:

Email: Phone number:

Describe your medical condition and the hardships it creates.

Section B: Medical Treatment/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.

Grant amount requested: $

Doctor and Facility Visited:

Address:

City: State: Zip:

Phone Number:

Describe the treatment you are seeking.

Why it is necessary to travel 90 miles or more to seek treatment/services? If follow up care at this facility will be necessary, include when and why. Please use additional paper if necessary.

C: 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:

ATTENTION!

BEFORE SUBMITTING YOUR APPLICATION, PLEASE ENSURE YOU HAVE PROVIDED THE FOLLOWING REQUIREMENTS AND HAVE PLACED A CHECK NEXT TO EACH SUBMITTED ITEM. APPLICATIONS WILL OTHERWISE BE CONSIDERED INCOMPLETE AND WILL NOT BE REVIEWED.

❑ Completed application with signature of pediatrician/primary care doctor or social worker

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

❑ Completed expense worksheet

❑ Receipts for reimbursement.