

## **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.
- Applicants requesting a grant of over \$1,000 may be asked to submit a current income tax return or other financial information.
- Grants will be reviewed four times per year at the Board of Directors' quarterly meetings. Approved grants will be awarded approximately 3 weeks after each meeting. Application deadlines and meeting dates can be found on [Jakeshelpfromheaven.org](http://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 or direct purchase of medically necessary or convenient items and services. I understand that I may be required to provide additional evidence of submitted information, including a current income tax return or other financial information. I give permission to Jake's Help from Heaven to contact the provided 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.