**Jake's Help from Heaven Travel Grant Application**

Jake's Help from Heaven, founded in 2011, is a non-profit dedicated to providing opportunities for those with medical challenges and disabilities to THRIVE.

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.

***AS OF 2024, INCOMPLETE APPLICATIONS WILL NOT BE SUBMITTED TO THE BOARD OF DIRECTORS FOR CONSIDERATION. THE FOLLOWING CRITERIA MUST BE MET:***

- A post-appointment letter or complete discharge notes from the treating doctor indicating reason(s) for treatment and the treatment dates.
- Completed Expense Worksheet with all columns totaled.
- Completion of the following application with the signature of a pediatrician/primary care doctor, social worker, or care worker.
- Receipts for reimbursement.
- To be eligible for reimbursement, the travel must have taken place within one year of the date that the application is being reviewed.
- 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.
- If you receive your requested item elsewhere, please alert us immediately so that we can withdraw your application. Failure to do so may affect your eligibility to apply in the future.

***IN ADDITION, PLEASE NOTE THE FOLLOWING POLICY CHANGES:***

- Please double-check that the applicant's address is listed correctly. JHFH is not responsible for replacing reimbursements mailed to the wrong address due to errors on the application.
- Applicants requesting a grant of over $1,000 may be asked to submit a current income tax return or other financial information.
- When individuals other than the applicant are completing the application, please write in the third person and do not write in the applicant's voice.

**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:

**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 incomplete.***

**Grant amount request: $ _____**

**Doctor and Facility Visited:**

**Address:**

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

**Phone Number:**

**Describe your medical condition and the hardships it creates.**

**Describe the treatment you are seeking.**

**Why is it 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.**

**Section 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 for 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, primary doctor, or care worker:

Printed name of social worker, primary doctor, or care worker:

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, social worker, or care worker.

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

❑ Complete expense worksheet.

❑ Receipts for reimbursement.

***If you receive your requested item elsewhere, please alert us immediately so that we can withdraw your application. Failure to do so may affect your eligibility to apply in the future.***