Jake’s Help From Heaven Travel Assistance 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. Jake never received an official diagnosis for his illness - although at the time of his death it was thought that he had a type of leukodystrophy, a group of disorders characterized by progressive degeneration of the white matter of the brain. 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 like Jake, we understand the importance of seeking medical care from the best specialists at top hospitals.

This Travel Assistance Fund 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 FDA-approved medical care and/or treatment, but lack adequate financial resources for the cost of this travel. Eligibility and program guidelines are as follows:

**Eligibility:**

* Applicants must submit medical documentation from pediatrician, doctor or specialist stating why medical treatment/services are being sought 90 miles or more away.
* **Applicants must live within 100 miles of Saratoga Springs, NY**
* Applicants must include all receipts for full or partial reimbursement.
* Completion of following application and worksheet with signature of pediatrician/primary care doctor or social worker.
* Grants will be awarded up to $2500. Grants over $1000.00 may be asked to submit current income tax return or other information. There is also a $2500 cap per applicant per calendar year. Applicants can apply more than once but for not more than $2500.
* 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 will be posted on facebook and on our website.

**Program Guidelines:**

* Eligible expenses include but are not limited to:
  + Air, rail, bus fare or mileage between patient’s residence and medical facility where treatment/services are received.
  + Travel and lodging for the individual seeking treatment and for a parent/guardian if the individual is a minor and/or cognitively or physically unable to travel without supervision/assistance.

Section A: Personal Information

Applicant: Age:

Parent/Guardian (if applicable):

Address:

City: State:

Zip:

Daytime phone #: Evening phone #:

Email address:

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: Financial information

Please indicate current family income:

Please indicate any other income (Public Assistance, Child Support, SSI benefits, Long or Short Term Disability, etc) received in the last year.

Have you applied to any other sources for financial assistance to accommodate this travel for medical treatment/services? If yes, please specify sources.

Section C: Medical Treatment/Services Information

Doctor/Facility:

Address:

City: State: Zip:

Telephone:

**Please submit a signed and dated letter from medical doctor on facility letterhead documenting the appointment.**

Section D: Travel Information

Start Date: End Date:

Please itemize your expenses below:

Cost of primary travel mode $

If using a personal automobile, please provide miles

travelled (round trip). If approved, mileage will be

compensated at the rate of $.24 /mile (gas is not reimbursable) $

Lodging up to $150 for accommodations at mid-scale hotel

for ***either*** night before ***or*** night of appointment (depending on

time of appointment) $

Meals for day of appointment and either day before or after

depending on time of appt (compensation up to $30/day with

receipts and excluding alcohol) $

Please provide all toll receipts $

TOTAL $

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 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 Travel Assistance Grant Announcements and related publications.

Signature of Applicant or Parent/Guardian:

Printed name of Applicant or Parent/Guardian:

Date:

Signature of social worker or pediatrician or primary doctor:

Printed name of social worker or pediatrician 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
* All receipts for travel reimbursement

Please use AND submit the worksheet below to help itemize your expenses.

|  |  |  |
| --- | --- | --- |
| Mileage at .24 / Day | | |
| From | To | Total Miles |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  | Total Mileage Requested |

|  |  |  |
| --- | --- | --- |
| Lodging | | |
| Facility | Dates | Total Lodging |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  | Total Lodging Requested |

|  |  |  |
| --- | --- | --- |
| Meals at $30 / Day | | |
| Venue | Date | Total Meal |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  | Total Meals Requested |

|  |  |
| --- | --- |
| Tolls | |
| Date | Amount |
|  |  |
|  |  |
|  |  |
|  | Total Tolls Requested |

Please use additional pages as necessary