



Application for Travel Assistance for Brain Tumor Patients

Miles For Hope assists brain tumor patients with travel assistance when flights are needed for them to receive treatment at a brain tumor center in the United States.

Please provide us with the information requested below to determine eligibility for flight assistance. If approved, Miles For Hope provides only flight assistance; no ground transportation or hotel assistance. Understand that submission of application does not confirm your eligibility for any financial assistance and additional information may be needed to determine eligibility. **All information contained herein will remain private and confidential.**

Name of Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Date of Birth: _____ Email: _____

Social Security Number (required): _____ - _____ - _____

Diagnosis: _____ Date of Diagnosis: _____

Is Patient currently employed?: _____

Name of Employer: _____ Phone: _____

Financial Information: Please provide the following information about the monthly finances of the household applying for assistance. Include a copy of the last 4 weeks of pay stubs for the household and any other information that may assist in determining eligibility.

Gross Income: \$ _____

Utilities Exp: \$ _____

Housing Exp: \$ _____

Medical Travel Exp: \$ _____

Groceries: \$ _____

Automotive Exp: \$ _____

Medical Exp: \$ _____

Debt Payments: \$ _____

Other Exp: \$ _____ (Please Explain) _____

Any other information you would like to share with us, for example, any recent financial changes that you think is important in determining your financial eligibility for flight assistance (use a separate sheet if necessary): _____



Tell us about your household. Include Name & Age (use additional sheet if needed)

| | Age | Living with you? |
|-----------------------|-------|------------------|
| Spouse/Partner: _____ | _____ | _____ |
| Child 1: _____ | _____ | _____ |
| Child 2: _____ | _____ | _____ |
| Child 3: _____ | _____ | _____ |
| Child 4: _____ | _____ | _____ |

Name, address & phone of Physician(s) treating for brain tumor: _____
_____ Phone: _____

If surgery was performed, please provide us with the Physician's name, their address and hospital where surgery was performed: _____
_____ Phone: _____

Was the patient enrolled in a clinical trial? Please provide us with the type of trial, Physician's name, address and Hospital or Center of trial: _____
_____ Phone: _____

What is the anticipated or actual date of the appointment you need flight assistance for?: _____

What facility will the patient need to travel to?: _____

What is your expected airport/city of travel for this appointment?: (ie; Charlotte, NC to Los Angeles, UCLA, etc)

Can patient travel alone or will a family member or friend need to accompany patient? Upon flight assistance approval, Miles For Hope may approve up to one companion to fly with the patient _____

If so, please provide name of person who will be traveling with patient (name as it appears on their Driver's license or passport): _____

List any special travel accommodations or needs that might be required for the patient. (ie; Wheel chair etc): _____



How were you referred to Miles For Hope?: _____

Are you related to or know anyone associated with Miles For Hope? If so, who and how:

Please provide us with any information you believe is important for us to know regarding your request for travel assistance: _____



Waiver and Release

In consideration of my acceptance of financial aid or benefits from Miles For Hope, I hereby, for myself, my heirs, my executors and administrators, waive any and all claims I may have against Miles For Hope, Inc., its employees, agents, representatives, assigns, and anyone else working with them, as well as all participating groups and any other individuals associated with Miles For Hope, Inc., as well as all of these individuals and groups for any and all injuries and/or damages that may be sustained by me in any manner arising out of or in connection with Miles For Hope.

In addition to the foregoing, and in further considerations of my acceptance of financial aid or benefits from Miles For Hope, Inc., I agree to use my image and any photos, motion pictures, recordings, or any other form of record for this event for any legitimate purpose. Furthermore, I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

In filling out this form I acknowledge that I have read and fully understand the terms of this Waiver and Release and expressly agree to all such terms without reservations.

Patient/Legal Guardian

Witness

Print Name

Print Name

Date

Date

Miles For Hope Representative

Date Reviewed

Authorization for Release of Information



To ensure the continuity of my medical care, I hereby authorize Miles For Hope and its representatives to discuss my Application for Financial Assistance, (including but not limited to my financial information, diagnosis and treatment) and related medical care with my physicians, medical representatives, and financial advisors as needed. I also authorize the release, as needed, of any medical records and information by my medical providers to Miles For Hope.

Patient/Legal Guardian

Witness

Print Name

Print Name

Date

Date

Miles For Hope Representative

Date Reviewed

Once completed, fax or mail the completed application, along with the required information to:

Fax
727-781-6425

or by mail:
Miles For Hope
1684 N Belcher Road
Clearwater, FL 33765