



Questions? Please contact Shirley at 610-649-3034 or email Shirley@AlexsLemonade.org

TRAVEL FUND PROGRAM

http://www.alexslimonade.org/travel-fund

SECTION ONE: PATIENT INFORMATION

Patient's First Name, Patient's Last Name, Date of Birth, Gender, Ethnicity, Address, City, State, Zip Code, Patient's Diagnosis, Date of Diagnosis, Stage of Cancer, Relapse, Relapse Date, Type of treatment, What is the name of the patient's original hospital?, Is the patient covered by Medical Insurance?, If so, what is the name of the carrier?

SECTION 2: FAMILY INFORMATION

Parent/Caregiver Name, Home #, Work #, Cell #, E-Mail, Status of Parent/ Caregiver(s), Family Size, Number of siblings, Their ages, Estimated Annual Gross Family Income

SECTION 3: HOSPITAL AND REPRESENTATIVE INFORMATION

Physician's Name, Physician's Telephone, Representative's Name, Title, Representative's Hospital Name, Telephone #, Pager #, E-Mail, Fax #

**SECTION 4: RESOURCES & DESCRIPTION OF NEED**

Is the family receiving support from other agencies? Please check all that apply:

*(Please ensure that existing resources have already been maximized before applying. This program is intended to only fund additional out-of-pocket travel expenses for the families)*

- Angel Flight       CancerCare       Candlelighters       Leukemia & Lymphoma Society
- Medicaid       National Children’s Cancer Society       Ronald McDonald House       Private Hospital Fund

Other(s): \_\_\_\_\_

What is the family requesting assistance for? (Check all that apply)       Transportation       Lodging       Meals

*Please give a detailed description of the family’s need for assistance, including an estimate of the patient’s treatment duration, and an approximation of their expenses in accordance with the ALSF Travel Program guidelines. Include a brief narrative for the patient’s treatment history and explain how the patient’s medical expenses have affected the family’s finances. You may add additional pages if needed.*

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Applications are only accepted through a certified representative – usually the patient’s doctor, nurse or social worker (called the “representative”), who is listed in Section 3. All sections of the form must be completed completely and truthfully. Any false, incomplete or misleading information will result in an automatic denial. Consideration shall be determined based on all factors as noted in this application and in accordance with the Travel Program Guidelines.

Alex’s Lemonade Stand Foundation (“ALSF”) provides equal opportunity for all eligible patients and their families. ALSF does not allow discrimination based on race, color, religion, national origin, gender, age, sexual orientation, disability, or any other basis under federal/local laws.

**SECTION 5: CONSENT**

By signing this application, I attest and agree to the following:

- (a) I am the representative listed above, and I am authorized to submit this application on behalf of the patient and the family.
- (b) A parent or guardian of the patient has given his or her consent to provide the information in this application, as well consent to the release of medical and financial information, and has agreed to sign any additional forms and consents related to this application.
- (c) The information provided in this application is truthful and accurate. ALSF shall be immediately notified if any information in this application changes, including the patient’s or family’s financial situation, insurance status, or the patient’s medical condition.
- (d) ALSF will not be responsible or liable for any reason to the patient, the family or the representative, regardless of whether or not the ALSF grants any funds to this applicant or any other applicant.
- (e) If approved, ALSF may provide travel, lodging and basic living assistance to eligible patients and their families. The program is limited by available resources and may be discontinued or changed at any time.
- (f) I hereby give ALSF my consent to use my information listed in this application and to contact me to discuss the information in this application and any related materials.

\_\_\_\_\_  
Signature (Social Worker or other Medical Representative)      Date

\_\_\_\_\_  
Name (Social Worker or other Medical Representative)      Title

Please fax the completed application to 610-649-3038, Attention: Shirley Moy. Thank you!