

◆◆◆◆◆ THE FOUNDATION OF CVPH TRAVEL FUND ◆◆◆◆◆

Applicant's Name _____ Date of Birth _____

Next of Kin _____

Address _____

Telephone Day _____ Evening _____

Place(s) of Employment _____

Address _____

Estimated Annual Family Income \$ _____

Insurance and Other Available Sources of Funding _____

If you are receiving assistance from social services, may we discuss your case with them? Yes / No.

Contact Person & Phone _____

Applicant's Primary Physician _____

Address _____

Telephone _____

Please Describe Applicant's Illness/Injury _____

Date of Onset _____

Where Is Care Being Provided? _____



Please Attach The Following:

- 1) A copy of page one of your income tax return for the previous year.
- 2) An itemized list of expenses.
- 3) Receipts (originals preferred, copies are acceptable).
- 4) Proof of physician appointment.

Please Note: Not more than one adult may apply for reimbursement. The Foundation of CVPH Travel Fund does not cover expenses for children. Reimbursement for food does not include alcohol and may not exceed \$15 to \$25 a day, based on location.



I hereby give my permission for The Foundation of CVPH Medical Center acting in behalf of the Foundation of CVPH Travel Fund to verify information provided on the above application with health care providers and employers listed.

Signature _____ Date _____

If you have questions or would like help in completing this form, contact The Foundation Office of CVPH Medical Center, 75 Beekman Street, Plattsburgh, NY 12901, Telephone (518) 562-7168.