Travel for Treatment
Travel & Lodging Assistance Form

Today's Date _____ / _____ / _____

Family Information

Patient Name

_____
Last First M.I. name you would like us to use

Mother's Name _____ Father's Name _____

Patient's Address

_____
Street City ST Zip

Mailing Address

_____
Street City ST Zip

Home Tel _____ Cell _____ Parent(s)E-mail_____

Other children and their ages who are living at the same address_____

Do other people reside at the same address (grandparents/friends)? _____ YES _____ NO

Are both parents living at the same address? __ YES __ NO If no, is there child support? __ YES __ NO

If no, why not? _____

Employment Information

Mother's Employer _____Length of Employment_____

Employer Address

_____
Street City ST Zip

Employer Tel _____Supervisor Name _____

Occupation _____Title/Position _____

Full-Time____ Part-Time_____ Do you receive paid time off when you take your child to the hospital?
__YES__ NO
If yes, how long will this be offered? _____

Father's Employer _____Length of Employment_____

Employer Address

_____
Street City ST Zip

Employer Tel _____ Supervisor Name _____

Occupation _____Title/Position _____

Full-Time____ Part-Time_____ Do you receive paid time off when you take your child to the hospital?
__ YES __ NO
If yes, how long will this be offered?
_____

Financial Information

Mother's Monthly Net Income $_____Father's Monthly Net Income $_____

Other Monthly Net Income $_____Source of Other Monthly Net Income_____

Total Monthly Net Income $_____

Do you receive any of the following benefits? (please check all that apply)

☐ Welfare ☐ ADC ☐ Food Stamps ☐ Medicaid ☐ SSI Who is covered? _____

Do you _____ OWN or _____ RENT your home? Monthly payment $_____

Do you use Assisted Housing? ☐ Yes ☐ No

Are any other non-profit organization(s) assisting you? ☐ Yes ☐ No

If yes, what organization(s) and how are they assisting you? _____

Do you own an automobile? ☐ Yes ☐ No If yes, how many? _____

Do you have automobile insurance? ☐ Yes ☐ No

Automobile 1: Year _____Make/Model _____ Is it in good working condition? ☐ Yes ☐ No

Automobile 2: Year _____Make/Model _____ Is it in good working condition? ☐ Yes ☐ No

Insurance Company_____ Name of Agent _____

Driver's License Info: Driver's License Number _____ State ____ Exp Date _____

Patient Information

Patient Name

_____
Last First M.I.

Date of Birth _____ / _____ / _____ Age _____ School_____

What is the medical diagnosis? _____ Date of Diagnosis: _____ / _____ / _____

Please give a brief description of the medical problem

_____

_____ Date treatment began: _____ / _____ / _____

Is this an ___ on-going problem/treatment or a __ one-time problem/treatment? Is this a birth defect? ☐ Yes ☐ No

Local Doctor Name

_____

Doctor's Address

_____

Street City ST Zip

Doctor's Telephone _____ [We will contact the Doctor to verify information.]

Where will treatment take place? Hospital _____ City _____

Is there a social worker in Reno/Sparks that is familiar with this case? ☐ Yes ☐ No

If yes: Name_____ Telephone _____

Is there an outlying social worker that is familiar with this case? ☐ Yes ☐ No

If yes: Name_____ Telephone _____

Ronald McDonald House Charities Northern Nevada assists with travel and lodging. What other assistance do you feel you need? Please explain:

_____

_____

How did you hear about our assistance program?

_____

Health Insurance Information

Is the patient covered by health insurance? ☐ Yes ☐ No Is insurance covering the treatment? ☐ Yes ☐ No

Primary Insurance: Health Insurance Name

_____

Subscriber's Name

_____

Policy/ID No. _____ Group No. _____ Deductible Amt $_____

Secondary Insurance: Health Insurance Name

_____

Subscriber's Name

_____

Policy/ID No. _____Group No. _____ Deductible Amt $_____

Permission to Obtain Information

A credit check may be obtained on all applicants applying for Adopt-A-Night Travel & Lodging Assistance.

I grant permission for the Ronald McDonald House Charities, Northern Nevada to obtain a credit check on me.

_____ Soc Sec # ____ ____ ____ / ____ ____ / ____ ____ ____ ____

Name of Person Completing Application (please print)

_____ _____ / _____ / _____

Signature Date

As your application is reviewed we may ask you to provide supporting documents.