

FIRST STEP CHARITY

Application for Medical Travel Assistance

FIRST STEP CHARITY RESPECTS THE PRIVACY AND CONFIDENTIALTY OF ALL APPLICANTS AND WILL KEEP ALL INFORMATION STRICTLY CONFIDENTIAL

Please answer all questions completely. If you need additional space, you may use a separate sheet of paper. Where possible, First Step Charity prefers that you submit applications in advance. In cases where requests are not submitted in advance all applications must be submitted within 30 days of the medical travel date to be valid.

If you need help completing this application, please contact First Step Charity

Mark Wilkoff

Phone: 709-623-2007

Email: mark@wilkoff.com

Please note that further information may be requested prior to final approval

Applicant Information	
Name:	Phone:
Address:	Cell:
	Email:
Medical Travel Details	
Purpose of travel: <input type="checkbox"/> Oncology <input type="checkbox"/> Radiology <input type="checkbox"/> Surgical <input type="checkbox"/> Rheumatology <input type="checkbox"/> Orthodontics <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Other: _____	
*Proof of appointment required	
Where are you required to travel for medical treatment? _____	
Are you travelling to the nearest treatment center? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, why? _____)	
Is there someone travelling with you? <input type="checkbox"/> Yes (If yes, please provide: Name: _____ Relationship: _____) <input type="checkbox"/> No	

How are you required to travel?

☐ Air ☐ Personal Vehicle ☐ Bus ☐ Other: _____

Have you (or will you) apply for financial assistance elsewhere?

☐ MTAP ☐ Hope Air ☐ Private/employer Insurance Policy ☐ Workplace NL ☐ Income Supports
☐ Other: _____

☐ Yes (If yes, how much will you receive? _____ ***Proof Required**)

☐ No

How much are you requesting?

☐ Bus \$ _____
☐ Air \$ _____
☐ Personal Vehicle \$ _____
☐ Hotel \$ _____
☐ Meals \$ _____

***Receipt Required following travel**

Expected Dates of travel:

Departure: _____

Return: _____

***Proof of Doctor's Visit required following travel**

Signature

Date

By signing you are agreeing to provide proof of receipts and travel as indicated throughout the form.

*Failure to do so may result in no reimbursement or may impact future application processes.

Are there any other travel/accommodation resources available to you (including family/friend's housing)? ☐ No ☐ Yes (if yes, please explain)

Approved Amounts

Bus: _____

Air: _____

PV: _____

Hotel: _____

Meals: _____

Other: _____