ADIRONDACK HEALTH TRAVEL FUND APPLICATION

Please complete form, attach all of the following.

- ☐ A copy of page one and two of applicant's federal income tax return for the previous year
- ☐ An itemized list of anticipated travel expenses

Patient's Name _____ Date of Birth _____

Address _____

Phone Number _____ Travel Companion _____

Email Address _____

Estimated Annual Household Income _____

Patient/Guardian's Employer _____

Reason for travel

Physician Referring You Out of Area _____

Where is care being provided? _____

Form completed by: _____

A committee will review the application and you will be notified of the results. Please note that if approved, patient will be asked to provide receipts for transportation expenses and food. Reimbursement does not include alcohol. Patient will also need to provide proof of medical appointments.

If you have any questions, please contact The Adirondack Health Foundation office.

Please mail completed forms and attachments to:
Adirondack Health Foundation, ATTN: Travel Fund
PO Box 120, Saranac Lake, NY 12983