



RONALD McDONALD  
HOUSE CHARITIES®  
NORTHERN NEVADA

# 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 Information: 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 Amount \$ \_\_\_\_\_

Secondary Insurance:

Health Insurance Name

Subscriber's Name \_\_\_\_\_

Policy/ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ Deductible Amount \$ \_\_\_\_\_

## 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.

\_\_\_\_\_  
Name of Person Completing Application (please print) Soc Sec # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

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

## Approval

Approved By: \_\_\_\_\_  
Name Title

\_\_\_\_\_  
Phone Number \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date