RONALD MCDONALD HOUSE CHARITIES® NORTHERN NEVADA

Hospital Travel for Treatment Form

Today's Date _____ / _____ / _____

Family Information

Patient Name

_____

Last First M.I. Age/DOB

Mother's Name _____ Father's Name _____

Patient's Address

_____

Street City ST Zip

Mailing Address

_____

Street City ST Zip

Diagnosis and Transfer Information

DIAGNOSIS: _____

DESTINATION HOSPITAL OR TREATMENT FACILITY: _____

AUTHORIZING NURSE OR SOCIAL WORKER: _____

Financial Information

Family 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? _____

Approvals

PARENT SIGNATURE AND AGREEMENT TO TERMS: _____ DATE: _____

RMHC STAFF APPROVAL: _____ DATE: _____