Vascular Birthmarks Foundation
VBF
www.birthmark.org

Brian C. Weber Memorial Travel Fund
Application

Thank you for contacting the Vascular Birthmarks Foundation for assistance with medical travel expenses. The information is used to verify an applicant's need for a possible KTS diagnosis or KTS treatment, understand current needs, and consider available resources. You may choose *Save As* from the FILE menu, and add your last name to the file name. Then, you may submit it as an attachment to an email or mail it in.

APPLICANT INFORMATION Date of application: ________________

Applicant's Full Name: ____________________________________ Date of Birth: _____________

Street Address: ____ Apt: ___________

City: ____ State: _________ Zip: ______________

Parent/Guardian Name(s) ____

Home Phone ________________________ Mobile number____________________________

E-Mail ____________________________________ Alternate E-Mail _______________________________

Our only way to know you is through this application. Therefore, please tell us your story and include a photo of yourself (or family) so that we might better understand your need for assistance.

Briefly explain your circumstances/case/symptoms and current issues resulting in financial need:

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APPLICANT NAME:____________________

MEDICAL INFORMATION

Diagnosis ____ Date of diagnosis: ____________
Currently under the care of:
Provider ________________________________ Facility ___________________________________
Address ____
Phone ______________________ Fax __________________ Email ___________________________

Would like to be evaluated or treated by:
Specialist ________________________________ Facility ___________________________________
Address ____
Phone ______________________ Fax __________________ Email ___________________________
Requesting:
☐ diagnostic ☐ radiology ☐ laser ☐ surgery ☐ pharmacy ☐other___________________________

FAMILY RESOURCES

Have health/medical insurance? No ☐ Yes ☐ Name of plan ______________________________

Covers medical travel expenses? No ☐ Yes ☐ Amount allowed? __________ Used? ___________

Contacted other agencies for assistance? No ☐ Yes ☐

Have other agencies provided assistance? No ☐ Yes ☐ Which agencies and amount provided?

___________________________ _________________________ ________________________

Total after tax household **income** per year (including all persons in household) $ _________________

Past due medical bills? No ☐ Yes ☐ Approximate amount $_____________

Ongoing pharmacy expenses? No ☐ Yes ☐ monthly amount $___________

Total other monthly debt/liabilities? No ☐ Yes ☐ monthly amount $__________

REQUEST FOR ASSISTANCE

Total cost of travel: $_____________ Amount of assistance you are requesting: $_____________

miles need to travel _______________ ☐car ☐air ☐bus ☐train

If awarded, do you agree to submit receipt(s) as proof of expenses? Yes ☐ No ☐ Reason why not?

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I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Vascular Birthmarks Foundation and Brian C. Weber Memorial Travel Fund administrators to obtain from the individuals and entities listed in this application whatever information is necessary about my case that might be helpful for assessing my application. I release Vascular Birthmarks Foundation of all liabilities or claims arising out of the donation of money or services provided to me or my family.

Applicant/Parent Signature: _______________________________________ *Date:* ______________

APPLICANT NAME:____________________

PUBLICITY NOTICE RELEASE:

I hereby acknowledge that the Vascular Birthmarks Foundation may use __________________'s name, photo, background and story in marketing materials which will include, but not be limited to, its newsletters, website, mailings and general information brochures. I understand and agree that granting of assistance may result in publicity whether or not VBF actively takes steps to publicize the award. The Vascular Birthmarks Foundation agrees that all protected health information will remain confidential and any reports written about the program will not use recipients' names without this express permission.

Applicant/Parent signature: __________________________ *Relationship* ___________ *Date* __________

MEDICAL RELEASE: *Please read and sign below.*

I, ______________________________, hereby release ____________________________(physician name) and members of his/her staff to communicate via letter, phone, or fax with The Vascular Birthmarks Foundation and its representatives for the purposes of confirming that my self/son/daughter ______________________________ is a patient being treated for ____(diagnosis).

Applicant/Parent signature: ___________________________ *Relationship* ___________ *Date* _________

PHYSICIAN CERTIFICATION STATEMENT—TO BE COMPLETED BY PHYSICIAN:

Patient's Name: ____ Date of Birth:_______________

Patient's Diagnosis/Site:____

How long have you been treating this patient? ___________________

Is patient in active treatment? If yes, please indicate type of treatment: __________________________

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Explain why patient must travel for a diagnosis or treatment and any additional information that would support this application for financial assistance:

I certify that the above listed information is accurate and current.

Physician's Signature:_______________________Telephone: _______________Date: ______________

Printed Name:______________________________Address:_____________________________________

Send completed application and photo to
VBF-Weber Memorial Fund, PO Box 106, Latham, NY, 12110,
or email as attachments to vbfawareness@gmail.com
Questions? Call 610-301-4522.