PNH Patient Travel Assistance Fund Application

PNH Patients are eligible to apply for up to $500 in travel assistance, per PNH Patient each year. By completing and submitting this form, you hereby certify that you have read the qualifying requirements of this Application and certify there is a financial need to supplement your travel costs in connection with your diagnosis/treatment/therapy to meet with a PNH specialist for a visit or for a second opinion.

- I agree to provide the Committee with my PNH diagnosis from my Doctor's office;
- I agree to provide the Committee with confirmation of my Specialist appointment;
- I agree to provide the Committee with the name of the PNH Specialist who I plan to meet with;
- I agree any financial assistance I receive from the Travel Assistance Fund will be used for travel costs for me and or my travel companion to assist me with my appointment;
- I agree that I will receive no more than $500 irrespective of the total cost of my travel to see a PNH specialist. (Meal amounts must be consistent with government GSA per diem amounts by city: https://www.gsa.gov/travel/plan-book/per-diem-rates); and,
- I understand there are very limited Travel Assistance funds and the Committee will solely decide on the final amount of travel funds granted to me.

Signature: _____Date: _____

(Sign only if you agree with the above statements.)

I am a patient currently diagnosed as:

☐ PNH

☐ AA/PNH or AA/MDS/PNH

I am applying for a travel grant to assist with the following expenses: (Provide a brief description of your total cost of travel on this template and reimbursement will only be up to $500 to meet with a PNH Specialist)

EXPENSE TYPE	ESTIMATED COST*	PLEASE EXPLAIN COST DETAILS (How did you arrive at this estimate?)
Travel: Airfare, train tickets		
Ground Transportation: Bus fare, rental car expenses, mileage if using own car, parking, tolls, cab fare (or other car service)		
Lodging/hotel (reasonable costs please)		
Meals (reasonable costs please)		
Co-pays (covers copay for Dr. visit or required medical tests not covered by your insurance)		
Miscellaneous (Please explain)		
Total:		

PATIENT INFORMATION: (Confidential to PNH Patient Committee and AAMDSIF)

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Gender: Male ____ Female ____ Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

PARENT/GUARDIAN INFORMATION (if PNH Patient is under age 18)

Contact Name: _____

Contact Relationship to Patient: _____

Contact Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

DISEASE AND TREATMENT INFORMATION

Patient's Primary Diagnosis: _____Date of PNH Diagnosis: _____

Full Name of Current Treating Physician Name: _____

Phone number of treating physician: _____

REQUESTED SPECIALIST:

Specialist Full Name: _____

City: _____ State: _____

Phone: _____ Email: _____

CERTIFICATION

I hereby certify that this information is accurate and I agree to release this information to the PNH Patient Committee and its members.

Signature:_____

Name (Print):_____

Date:_____

SUBMISSION INSTRUCTIONS:

Scan/email to: **PNH Patient Committee**
Email: **pnhpatientcommittee@aamds.org**