PATIENT MEMBER TRAVEL APPLICATION FORM

(as part of the DEBRA Canada Medical Assistance Fund (MAF) Program)

Please Read Details of the Application:

1. The Medical Travel Application form is part of DEBRA Canada's Medical Assistance Fund (MAF) program. This form can be used to request travel for medical appointments and can be used to apply for non-medical travel (conditional on the approval by the DEBRA Canada Board of Directors).
2. Only DEBRA Canada members are eligible to apply for travel support.
3. Membership to DEBRA Canada is free and can be applied for at the time of a travel application.
4. **Applications should be submitted a minimum of 4 weeks prior to proposed travel dates**. Earlier exceptions (prior to 4 weeks of the travel date) will be considered on an emergency/ case by case basis.
5. Your cost estimate should be based on economy travel fares, and standard accommodation/rooms for hotels. Feel free to ask DEBRA Canada for recommendations for hotel stays.
6. Please email your application form to the contact address provided below.
7. Applications will be discussed and decided upon by the Executive Committee of DEBRA Canada + DEBRA's Medical Assistance Fund Officer.
8. The number of people that can be funded per family is generally 1 patient and 1 care-giver; however, exceptions can be made at the discretion of the DEBRA Board of Directors or Executive Team.
9. Successful and unsuccessful applicants will be informed promptly.
10. Please note, travel receipts must be provided as proof of funds to be reimbursed (e.g taxi, shuttle, etc.) DEBRA Canada prefers to book travel (airline, train) or hotel directly with the vender on a member's behalf.
11. If your funding request is approved, you will be asked to provide a short report on how the travel grant has helped, by 1 December of the same year. Please use the reporting form available on the DEBRA Canada website. These reports may be presented to the community through DEBRA Canada's communication channels E- newsletter, e-blasts and website) as examples of how DEBRA can provide support to patient member families.

Please submit this application form, preferably by e-mail (otherwise by mail or fax) to:

debra@debracanada.org (Reference: Application – Patient Member Travel Application)

Otherwise by mail or fax to:

By Fax: 905- 469-1850 (ATTN: DEBRA Canada, Patient Member Travel Application Request)

By Post: (please note: this option may result in significant delay in response from our Committee)
ATTN: DEBRA Canada (Medical Travel Application Request)
1500 Upper Middle Rd, Unit #3
PO Box 76035
Oakville, ON, L6M 3H5

If you have any further questions, please contact:Erin Hoyos, Secretary/Administrative Officer: ehoyos@debracanada.org

PATIENT MEMBER TRAVEL APPLICATION FORM

PLEASE SUBMIT REQUEST MINIMUM 4 WEEKS PRIOR TO APPOINTMENT/ TRAVE DATES

Please Note: Submissions with less than a 4 weeks lead time will be accepted on a case by case basis or on an emergency submission request.

Is this an Emergency Request?

Yes ☐ No ☐

DATE SUBMITTED: _____

DATE RECEIVED (DEBRA OFFICE ONLY): _____

A. APPLICANT

Note: The applicant must be from a current or associate (i.e. medical) member of DEBRA Canada.

Name of Patient Member (First Name, Last Name)	
Applying on Behalf of a Patient Member: **First Name, Last Name, Organization (if applicable)** **(Please specify relationship to patient member)**	
Street Address:	
City, Province & Postal Code:	
Email Address:	
TRAVEL DATES : **(DD/MM/YYYY) – (DD/MM/YYYY)**	

B. SUPPORT REQUESTED

1. Detail Medical Institution (or other) you wish to be funded to travel to.

Name of institute	
Location	
Date(s)	

2. Please outline, in a few sentences why you are asking for travel funding and how this will assist you with your EB care and/or quality of life.

3. Estimated Cost of Support Requested

Travel costs in CAD **For Plane Travel:** NB: only economy travel for plane or train Please provide two competing - lowest cost options / quotes.	*Please outline which, e.g. "Air Canada ticket Toronto – Ontario"* *For airfare, please include flight No.*	_$___CAD _____CAD
For car – please state Km's (return trip). Please use google maps to estimate KM's	_____Km return (Please provide KM based on Google Maps)	$ _____ CAD
For Taxi/ Shuttle Services for people with reduced mobility – Please estimate return fair. Please specify taxi company and fairs quoted.		$_____CAD
Accommodation Quote NB: in any of the accommodations reserved or suggested by conference host.	*Please state name of hotel and number of nights.* *Specify:*	_____ CAD _____ USD (if applicable)
Other Services (please provide estimates, final receipts must be submitted for reimbursement) * Hold onto your receipts e.g. Parking, food/meals ***Please note:** **Toronto EB Clinic Hospital for Sick Children provides paid Parking & Meal Vouchers**	Specify: Specify:	$ _____ CAD $_____CAD
	ESTIMATED TOTAL	**$_____CAD**