PNH Patient Travel Assistance Fund Application

PNH Patients are eligible to apply for up to $800 in travel assistance, per PNH Patient each calendar 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 with whom I am scheduling/have scheduled an appointment.
- 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 $800 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.
- **Application MUST be submitted in advance of the appointment for consideration.**

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 or MDS/PNH

(Provide a brief description of your total cost of travel below. Reimbursement will be no more than $800 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 another car service)		
Lodging/Hotel (reasonable costs, please)		
Meals (reasonable costs, please)		
Co-Pays (covers co-pay for doctor visit or required medical tests not covered by your insurance)		
Misc. (please explain)		
Total:		

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

Patient First Name: _____
Patient Last Name: _____
Street Address: _____
City, State, ZIP: _____
Phone #: _____
Email Address: _____
Date of Birth: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____

PARENT/GUARDIAN INFORMATION IF PNH PATIENT IS UNDER 18

Contact First Name: _____
Contact Last Name: _____
Street Address: _____
City, State, ZIP: _____
Phone #: _____
Email Address:

DISEASE & TREATMENT INFORMATION

Patient 's Primary Diagnosis: _____
Date of Diagnosis: _____
Full Name of Treating Hematologist/Oncologist: _____
Phone # of Treating Hematologist/Oncologist: _____

REQUESTED SPECIALIST

Full Name of PNH Specialist: _____
City, State: _____
Phone #: _____
Email Address: _____

CERTIFICATION

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

Signature: _____
Name (Print/Type): _____
Date: _____

SUBMISSION INSTRUCTIONS:

Complete relevant sections of the application and scan/email or fax to:
Subject: PNH Patient Travel Assistance Fund
Email Address: help@aamds.org
FAX: 301-279-7205
If you have questions or need assistance, please call (800) 747-2820 x2 or send an email to help@aamds.org.

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