Fund Request Form

Please use this form when requesting funds from a Help Hope Live Regional Restricted Fund.

Help Hope Live

- For faster payments: fill out this form, scan it, and attach it in an email to FundRequest@helphopelive.org. You can also mail this form to Help Hope Live.
- **Approved requests will be processed within 5-8 business days.**
- Requests are to be for medically related expenses and accompanied by proof of expense (invoice, receipt).
- Please refer to our **Fund Disbursement Guidelines** for additional information.
- Requests must be submitted with a separate form for each payee address.

Date: _____

Client/Campaign Name: _____

Requested by: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

If this request is to pay an independent contractor (such as for caregiving, therapy, home modifications, auto repair), we will need their Form W-9 (Request for Taxpayer Identification Number and Certification) before remitting payment.

Amount Requested: _____ ☐ *The payee is enrolled in direct deposit with Help Hope Live.*

Payable to: Name: _____

Send to: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please total your expenses in each category. An invoice or receipt is required for all requests.

Medical: _____ **Travel /Mileage:** _____

Medications: _____ **Relocation/Lodging:** _____

Insurance: _____ **Other:** _____

Explanation/Comments (if necessary): _____

_____

For Office Use Only:

B/U: _____ EG: _____ Approved By: _____ Date: _____

W-9: _____ Verified: _____ Vendor ID: _____ Amount to be paid: _____

Travel Expense Log

Help Hope Live reimburses car transportation expenses at the **IRS medical mileage rate of $0.18/mile** to help pay for gas and wear on your car. This includes trips to a medical center, therapy, doctor's office, or other medically related travel. Parking fees and tolls may also be submitted. A detailed itemization (such as an itinerary or MapQuest printout) of your medical travel is necessary. Do not send gas receipts.

Date of Travel	Destination	Miles Driven (round trip)	Mileage Rate	Total Mileage	Tolls	Parking	Total Travel Cost
Sample: 1/5/2018	St. Christopher's Hospital	40	$0.18	$7.20	$2.00	$5.00	$14.20
			$0.18				
			$0.18				
			$0.18				
			$0.18				
			$0.18				
			$0.18				

Grand Total:

Temporary Relocation – Daily Food Log

Please include proof of medical treatment received during travel, such as a doctor's note, parking receipt, or invoice.

Individuals	Dates	# of Days	Rate Per Day	Total
Client			$40	
Caregiver (During Client Hospital Stay)			$40	
Client & Caregiver			$65	

Grand Total:

Help Hope Live

2 Radnor Corporate Center
Suite 100, 100 Matsonford Road
Radnor, PA 19087

P: 800.642.8399
F: 610.535.6106
helphopelive.org

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