



Alex G. Duncan Foundation

for Fighting Testicular Cancer

Alex G. Duncan Foundation Medical Travel Reimbursement Application

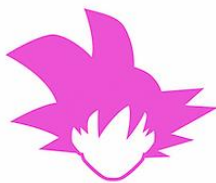
Alex was always a gift to our family, providing humor and inspiration despite all of the challenges he faced throughout his life. During his battle with testicular cancer, we received a tremendous amount of support, encouraging Alex and helping us through an extremely emotional and difficult journey. When Alex was given a financial gift from a very close friend, his immediate response was to donate it. Instead, he decided that he wanted to help others that are battling testicular cancer like him. The Alex G. Duncan Foundation was established in February 2021 as Alex's way of paying it forward.

Though Alex lived in Niskayuna, NY, his care led to trips across the country to San Diego, Houston, and often to New York City. With illnesses, like testicular cancer, we understand the importance of seeking medical care from the best specialists at top hospitals, so this Medical Travel Reimbursement was created to assist patients and families seeking the most ideal medical care.

Awards will be given to families that travel over 90 miles from home to seek medical care and need financial assistance for the cost of this travel. Applicants may apply for up to \$2,500 for travel reimbursement annually. Candidates may apply more than once per year but total reimbursement may not exceed \$2,500.

Applications will be reviewed monthly by the Board of Directors.

Please note that even if you are a REPEAT APPLICANT, you must fill out a MEDICAL TRAVEL APPLICATION in order to be reimbursed for your medical travel.



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TRAVEL APPLICATION GUIDELINES

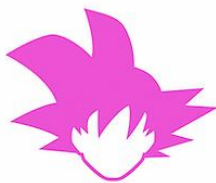
You must complete all Sections.
Incomplete applications may result in delay or denial of reimbursement.

Section A: Personal Information

To be completed by patient, parent, or legal guardian. Please provide all personal contact information.

Applicant Name:	Age:
Parent/Guardian (if applicable):	
Street Address:	City:
State:	Zip:
Phone #:	Email address:

Provide a brief description of the medical appointment along with an explanation of why it is necessary to travel beyond 90 miles from your home.



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Section B: Medical Treatment/Services Information

List the name of the facility you will be traveling to and include the facility address and telephone number. As validation of the appointment/treatment, provide a copy of the appointment dates on hospital/office letterhead.

Doctor/Facility:	
Street Address:	City:
State:	Zip:

If travel reimbursement is pre-approved by the BOD, after the appointment, complete and submit the travel expense worksheet (see Section C) and required documentation (see Section D). ****Be sure to bring Section D with you to your appointment as your doctor's signature is required.**

Section C: Travel Information

Fill out the Expense Worksheet **COMPLETELY**. For your convenience the Expense Worksheet may be downloaded from our website.

Provide beginning and ending of date(s). Complete all necessary columns on the expense worksheet. Please note the following:

1. MILEAGE – Mileage is paid at \$0.40 per mile. This amount is inclusive of all related transportation expenses (tolls and gas).
2. PARKING – Parking fees may be submitted for reimbursement. Receipts are required for verification.
3. LODGING – Lodging is paid at the rate of up to \$150/night. Please submit lodging receipt for verification.
4. MEALS – Meals are reimbursed at the rate of \$50/day for the day OF appointments only, or the duration of an inpatient hospital stay. Receipts are NOT required.



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**If travel is via bus, train or airplane please submit receipts indicating the tickets have been paid.

Section D: Disclosure/Signature

Read the declaration, answer the question to use your name in announcements or publications, and sign.

PRINT the signature form and bring to the appointment to obtain your doctor's signature.

I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge. I understand that what I submit to the Alex G. Duncan Foundation is for the purpose of financial reimbursement to enable travel for medical treatment/services. I understand that I may be required to provide additional evidence of submitted information and I give permission to a member of the Alex G. Duncan Foundation to contact the medical facility for verification purposes.

I agree to allow the Alex G. Duncan Foundation to use my name in announcements and related publications (circle your answer). YES NO

Signature of Applicant or Parent/Guardian:
Printed Name of Applicant or Parent/Guardian:
Date:
Signature of Doctor:
Printed Name of Doctor:
Contact Number:
Date:



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APPLICATION CHECKLIST

- Completed and signed application
- Medical letter from doctor on medical facility letterhead
- Completed Travel Expense Worksheet
- Required receipts for travel reimbursement