The Children's Hospital at Montefiore

Rett Center

ALEXANDRA LEWIS SCHOLARSHIP FUND APPLICATION

CANDIDATE INFORMATION

First Name	Last Name	Date of Birth	Social Security Number

Gender				
Male Female	Are you a U.S. citizen or lawfully admitted resident? Yes No			
RELATIONSHIP TO SCHOLARSHIP CANDIDATE				
I am the _____ of the Recipient. Father Mother Sister Brother Son Daughter Spouse Other				
If *Other*, please specify:				

CONTACT INFORMATION

Address			
Street		City	
State		Zip Code	
Phone #1		Phone #2	
Email Address:			

INCOME INFORMATION - Attach documents when returning application

Calculating Household Income:
*Use **Gross Income** when calculating income with **pay stubs**; **Adjusted Gross Income** when using **Federal Income Tax Return***

Yearly/Annual Household Income		No. Persons in Household	
Yearly $	*$*	**# Household Members**	#
***Select which income document was used to verify your household income and send a copy with this application.**	**Federal Income Tax Return (Most Recent Year)* ** Pay Stub(s)* ** W2*		

INSURANCE INFORMATION – Attach copies of insurance cards when returning application

PRIMARY INSURANCE			
Insurance Co. Name:		Subscriber Name:	
ID # Group #		Subscriber Date of Birth	
Insurance Co. Phone #:			

SECONDARY INSURANCE			
Insurance Co. Name:		Subscriber Name:	
ID # Group #		Subscriber Date of Birth	
Insurance Co. Phone #:			

ACCOMPANYING PERSON(S)TO APPOINTMENT

First Name:				Last Name:	
Date of Birth:				Address:	
City:		State:		Phone:	

REIMBURSEMENT REQUEST

	Follow-up Trip ***Up to 1 night***
HOTEL EXPENSES	
Will you require a hotel room?	
How are you traveling to the Rett Center? *Air, Car, Bus, Train*	
If traveling by air, proposed airfare cost roundtrip? Name of Airline	
If traveling by car, how miles will be traveled round trip?	
For Center use:	
Transportation to/from hotel	
Transportation to/from hospital	

REIMBURSEMENT OF TRAVEL AND EXPENSES _ ALEXANDRA LEWIS SCHOLARSHIP FUND
Candidate Attestation Form

I, _____as the parent/guardian of _____ patient of the Tri-State Rett Syndrome Center at Montefiore Medical Center (the "Center"), have truthfully and completely provided all the information requested in the application for reimbursement of travel and expenses for our appointment at the Center

In signing this form, I declare, that all the information I have provided is true, correct and complete. I further understand that Federal and State law may provide for penalties of fine and/or imprisonment or denial of the requested travel and subsistence reimbursement assistance if I do not tell the truth when applying for an award under the Alexandra Lewis Scholarship Fund, if I conceal or fail to disclose facts regarding the information supplied in the application process.

Applicants Signature: _____ Date: _____

Center Use:

Reviewed By: _____ **Date:** _____

Approved **Yes** _____ **No**_____ **Total Score** _____