KBIC Community Assistance Program

16429 Beartown Road, Baraga, MI 49908
Telephone: (906) 353-4162 Fax: (906) 353-4179

MEDICAL TRAVEL PROOF OF ATTENDANCE

The Purpose: Medical Travel/Service Assistance

It is provided for necessary medical specialist appointment(s) / procedure(s) for each eligible applicant and for out of area travel for immediate family members to visit a family member being hospitalized overnight or having to undergo medical/surgical procedure(s) that could possibly result in an overnight stay.

Required Proof of Attendance/Receipts: Due (5) Business Days following the visit.

1. Hotel Receipts
2. Proof of attendance and length of stay in hospital or visit for each day signed by a hospital representative for Medical Travel Advances
3. For Fuel Only Funding Assistance, the recipient must provide proof they attended the appointment prior to receiving any future funding through CNAP
4. If receipt totals for medical travel advances are less than funds provided, the balance must be returned to the program within 5 business days. If the funds are not returned, an individual will not be eligible for funds through CNAP until the amount owed is paid in full.

VERIFICATION OF MEDICAL ATTENDANCE/APPOINTMENT(S)

Patient's Name(s):_____
Attending Family Members or Drivers Name(s):
_____
Appointment Date(s): From: To:
Time of Appointment:_____
Location:_____
I certify that the above named person attended an appointment, was hospitalized, or was visiting a hospitalized family member on the date(s) and location listed above.

Verified by:_____Date:_____
(Doctor, Nurse, or other Medical Representative)

VERIFICATION OF MEDICAL ATTENDANCE/APPOINTMENT(S)

Patient's Name(s):_____
Attending Family Members or Drivers Name(s):
_____
Appointment Date(s): From: To:
Time of Appointment:_____
Location:_____
I certify that the above named person attended an appointment, was hospitalized, or was visiting a hospitalized family member on the date(s) and location listed above.

Verified by:_____Date:_____
(Doctor, Nurse, or other Medical Representative)

VERIFICATION OF MEDICAL ATTENDANCE/APPOINTMENT(S)

Patient's Name(s):_____
Attending Family Members or Drivers Name(s):
_____
Appointment Date(s): From: To:
Time of Appointment:_____
Location:_____
I certify that the above named person attended an appointment, was hospitalized, or was visiting a hospitalized family member on the date(s) and location listed above.

Verified by:_____Date:_____
(Doctor, Nurse, or other Medical Representative)

VERIFICATION OF MEDICAL ATTENDANCE/APPOINTMENT(S)

Patient's Name(s):_____
Attending Family Members or Drivers Name(s):
_____
Appointment Date(s): From: To:
Time of Appointment:_____
Location:_____
I certify that the above named person attended an appointment, was hospitalized, or was visiting a hospitalized family member on the date(s) and location listed above.

Verified by:_____Date:_____
(Doctor, Nurse, or other Medical Representative)