



Hotel Assistance Form - Request for Services

This request will be forwarded to the VHF Patient Assistance Committee for review. All identifying information will be removed from the request prior to sending for review.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Meeting Name: _____

How many family members will be attending? _____

What are their ages? For those 17 and over list "adult" as their age. _____

Reason for financial help of additional hotel room: _____

How will attending this meeting be of benefit to you and your family?
