

Teal Tea Foundation
Give Women a Lift
Request for Transportation Funding

Date of Request: _____

Requested By:

Name of Hospital/Clinic/Organization: _____

Address, City, State, Zip: _____

Contact Name: _____ Contact Phone: _____

Contact Email: _____

Patient Name: _____

Funding Request (select 1 option below, please print legibly):

Gift cards (mailed to Requestor at address above) Amount: _____

Direct payment to transportation provider (attach invoices) Amount: _____

Send payment to: Provider Name: _____

Provider Address/City/State/Zip: _____

Provider Contact and Phone: _____

Reimbursement for transportation expenses (attach receipts) Amount: _____

Send payment to: Recipient Name: _____

Recipient Address/City/State/Zip: _____

Recipient Phone: _____

I certify that the recipient has met all of the residency and financial qualifications to be eligible for Give Women a Lift program funds and the expense represents approved costs to/from patient appointments.

Signed: _____

Date: _____

(Social Services Representative)

Please email this form to our GWAL Coordinator at gwal@tealtea.org.

January 2020