



Medical Transportation Grant Program Application

Name of Hospital: _____
Address: _____
Address: _____
City/State/Zip: _____

Name and Title of person who would administer the Program:

Direct Telephone #: _____
Email address: _____

Name and Title of person who would sign the Letter Of Agreement (LOA):

Direct Telephone #: _____
Email address: _____

Hospital Specialty: _____

How many people travel specifically for the focus/specialty area(s) of health?

How many people are treated by the hospital annually?

How are out-of-town patients referred to the hospital?

Is there a designated department (such as Social Work, Travel Concierge, Patient Services) that would assist these patients with their travel? If so, please list and describe their roles:

Is the hospital affiliated with any umbrella hospital management companies or networks? If so, please describe. Include name, address, contact person, and whether the entity is a tax-exempt 501(c)(3) organization.

Does the hospital have any sponsorships, similar agreements, or programs with another airline or travel program? If so, please list.

Please provide your patient numbers in percentages:

Children under 18: _____

Adults 18-55: _____

Adults 55+: _____

If given an allotment of tickets, would the hospital be able to fulfill a monthly reporting and promotional requirement?

Please list any awards or recognitions the hospital has received:

Is there anything else you would like us to know about the hospital?

Completed by: _____ Date: _____

Please return by November 11, 2009 to:

Debbie Wafford
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