



“Lōkahi for Aloha” Fund Medical Assistance Request



LFAM

Personal Information – Please attach a copy of your March 31st Aloha Airlines pay stub and a copy of your 2007 tax return as verification

Name: _____

Street Address _____

City _____ State HI Zip Code _____ Island _____

Home Phone _____ Cell Phone _____

Work Phone _____ Fax _____

E-Mail Address _____

Family Members' Names	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Description of Medical Need

Debts – Please attach copies of the bills to be paid and list them in the order of priority	Amount Requested
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Applicant's Signature: _____ Date: _____

Accepted by	Date
Aloha Airlines Employee Committee	Lokahi Emergency Assistance Committee

Please fax or mail to:

The Lokahi Giving Project, c/o KHON2, 88 Pi'ikoi Street, Honolulu, HI 96814
E-mail mjones@khon.com • Office 808-591-4298 • Fax 808-591-4276