J. KIFFIN PENRY PATIENT TRAVEL ASSISTANCE FUND

Request for Travel Assistance Application
Criteria for Eligibility and Program Guidelines

The Epilepsy Foundation is able to provide this program through a generous gift from Cyberonics, Inc.

Effective January 29, 2013

The Epilepsy Foundation established the *J. Kiffin Penry Patient Travel Assistance Fund* in honor of J. Kiffin Penry. Dr. Penry, who died in 1996, is considered one of the most influential epilepsy leaders of his generation. He became a professor at Bowman Gray School of Medicine following a distinguished career at the National Institute of Neurological Disorders and Stroke (NINDS). Dr. Penry served for a number of years on the Epilepsy Foundation's Professional Advisory Board (PAB) and National Board of Directors.

Travel scholarships are available to individuals who have had to travel more than 50 miles from their home to receive **FDA-approved medical care and/or treatment for their epilepsy/seizure disorder, but lack adequate financial resources to meet the cost of this travel without bearing financial hardship.** Eligibility and program guidelines are as follows:

ELIGIBILITY

- Applicants must demonstrate financial need based on individual income tax return, evidence of financial hardship, and attempts to exhaust **at least three** other funding sources within the county and state where the patient lives in addition to their insurance company.
- Applicants must provide justification for obtaining medical treatment/services more than 50 miles outside of the patient's home for their epilepsy/seizure disorder. Official documentation from the patient's doctor, medical practitioner, or facility where treatment/services will be provided is required and must include the reason(s) for treatment, treatments received, and date(s) of treatment.
- Applicants may apply prior to travel for pre-approval, but must provide **original** receipts for final application consideration and funds disbursement.

APPLICANTS FROM AREAS SERVED BY AN AFFILIATE

Applicants in Epilepsy Foundation Affiliate-served areas must submit the **Request for Travel Assistance Application** directly to the Affiliate. The Affiliate will then review and verify the information provided by the applicant, sign the application, and forward it to Mary Ann Thornton at the National Office (1-800-470-1655, ext. 3732) on behalf of the applicant.

Applicants from Unserved (Unaffiliated) Areas

Applicants from unserved areas (areas where there are no state or local Epilepsy Foundation Affiliates) must apply directly to the Epilepsy Foundation's National Office by completing a **Request for Travel Assistance Application**. To locate any state or local Epilepsy Foundation Affiliates in a specific area, applicants can:

- Contact the Epilepsy Foundation at 1-800-470-1655 ext. 3732; or
- Visit the Epilepsy Foundation's Local Support page to locate an affiliate in the area.

All Penry Fund Travel Assistance Applications from applicants in **unserved areas only** must be directly forwarded to Mary Ann Thornton at the National Office (1-800-470-1655, ext. 3732).

Program Guidelines

- The **maximum** amount that can be awarded per individual within any 2-year time period is **$1,500**.
- Completed application packages must include original receipts and be submitted no later than 30 calendar days after the last day of travel. For example, if an applicant's travel spans May 16-19, the National office or Affiliate should receive a completed application package with receipts no later than June 19.
- Should an individual require further travel assistance within a one-year time period after the initial application submittal and notification of award, a request for additional funds may be made in the form of a supplemental letter. This letter must be submitted within 30 calendar days after the last date of relevant travel and include date(s) of travel, reason(s) for travel, and the amount requested. Each individual request will be subject to review as there is no guarantee of subsequent trip approval or fund availability.
- Eligible expenses include:
    - Air, rail, bus fare or mileage between a patient's United States residence and the facility where treatment is received; and/or
    - Lodging/hotel, parking, cab fare and tolls for the individual receiving treatment and an adult companion/parent if the individual receiving treatment is a minor and/or cognitively unable to travel without adult supervision/assistance.
- Expenses for medical treatment/services not directly related to the patient's epilepsy/seizure disorder will not be considered.
- Expenses that will not be approved include, but are not limited to:
    - Meals
    - Entertainment (i.e., in-room movies, etc.)
    - Personal hygiene items; medications/prescriptions
    - Cleaning supplies
    - Gifts
    - Alcoholic beverages
    - Gasoline (costs for gasoline are included in the mileage reimbursement)
    - Car repairs
    - Telephone
    - Non FDA or PAB approved treatment
- Scholarships are awarded on a first-come, first-serve basis until funds are exhausted during any given program year.

SELECTION PROCESS

A Review Committee will review each **Request for Travel Assistance Application**. The committee consists of an Epilepsy Foundation National Office staff member, an Epilepsy Foundation National Board Member, and an Epilepsy Foundation Affiliate representative, plus three alternates for each position.

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Request for Travel Assistance Application

Please Print Clearly

Section A. Personal Information			
Applicant/Patient		Age	
Parent/Guardian (if applicable)			
Address			
City		State	
Zip Code			
Daytime Telephone		Evening Telephone	
E-Mail Address			
Briefly describe the medical treatment that is required at this time. Are these services available closer to home? **Please include why it is necessary to travel beyond 50 miles from your home** (attach another sheet if necessary).			

Section B. Financial Information		
Please indicate your annual income as reported on your last Federal Tax Return. **Applicants must submit a copy of their last Federal Tax Return or Social Security Income yearly benefits statement.**	$	
Please indicate any other income (including Public Assistance, Child Support, SSI Benefits, Long- or Short-Term Disability, etc.) received during the last year	$	
How many people in your household are supported by the above income?		
What percentage of medical costs does your health insurance cover?	%	
How much is the deductible on your health insurance?	$	
Have you submitted travel expenditure documentation to your insurance company for reimbursement?	☐ Yes	☐ No
Do you and/or your child receive Medicaid?	☐ Yes	☐ No

Section C. Resource Information

Please list any resources (local churches, Lion's Club, Social Services, etc.) you have contacted to request/obtain travel assistance and the outcome			
(1)		☐ Granted	☐ Denied
(2)		☐ Granted	☐ Denied
(3)		☐ Granted	☐ Denied
Do you expect to receive any additional financial assistance from any other sources to accommodate travel for medical treatment/services?		☐ Yes	☐ No

(If yes, please specify other sources)	
(1)	
(2)	
(3)	

Section D. Medical Treatment/Services Information

Practitioner/ Facility Name			
Address			
City		State	
Zip Code			
Telephone			

Section E. Travel Information

Start Date		End Date	

Please itemize your expenses below
Original receipts of all expenses (except mileage) must be provided to receive reimbursement.

Cost of Primary Travel Mode (air, rail, bus, personal automobile, etc.)	$
If using a personal automobile please provide an estimate of miles to be travelled (Mileage will be compensated for at the rate of $0.30/mile).	
Lodging/Hotel	$
Parking, cab fare, other unusual expenses (please explain)	$
TOTAL	$

Section F. Disclosure/Signature	
I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge and is being provided to the Epilepsy Foundation for the purpose of receiving financial assistance consideration to enable travel for medical services. I understand that the maximum amount which can be awarded per family within any two-year period is $1,500 and the Penry Fund will consider one trip at a time for an applicant, but multiple requests can be made over a two-year period totaling $1,500 as long as the Fund has adequate resources. I further understand that I may be required to provide evidence of the submitted information, and authorize the Epilepsy Foundation to contact the appropriate Affiliate staff and/or medical practitioners for verification purposes.	
(Check One) I agree ☐/do not agree ☐ to allow the Epilepsy Foundation to use my name in Travel Assistance Fund Awards Announcements and related publications.	
Signature of Applicant or Parent/Guardian	
Date	

REQUIRED ATTACHMENT: Letter from health care provider or facility where the services will be rendered.

Section F. Epilepsy Foundation/Affiliate Statement	
I hereby affirm that I have reviewed this application along with the required supporting documentation and am in full support of this request for travel assistance.	
Name of Epilepsy Foundation/ Affiliate Representative	
Signature of Epilepsy Foundation/ Affiliate Representative	
Affiliate Site Name (if applicable)	
Date	

Please submit completed application package with supporting documents to your local Epilepsy Foundation Affiliate. Applications submitted directly to the Epilepsy Foundation National Office are only accepted if the applicant resides in an unserved area. It is strongly recommended that you keep a copy of this application package for your files.

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Affiliate Checklist

For National Office/Affiliate Representative Use Only

☐	Copy of Federal Tax Return/ Social Security Income yearly benefits statement	
☐	Medical Documentation	
☐	Proof of Appeal of Last Resort	
☐	Original Expenditure Receipts	
	☐	Travel (Air, Train, Bus, or Automobile)
	☐	Lodging/Hotel, cab fare and tolls

Affiliate Representative Signature	Date

Attach original receipts