



## ***J. Kiffin Penry Patient Travel Assistance Fund***

### **Request for Travel Assistance Application**

### **Criteria for Eligibility and Program Guidelines**

***The J. Kiffin Penry Patient Travel Assistance Fund program  
is supported by Novartis Pharmaceuticals Corporation and the Epilepsy Foundation.***

## ***J. Kiffin Penry Patient Travel Assistance Fund***

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 and National Board of Directors.

Travel assistance funds are available for individuals who must travel more than 50 miles from their home to receive **medical care and/or FDA approved treatment for their epilepsy/seizure disorder**, but lack adequate financial resources to meet the cost of this travel. Following are the criteria for eligibility and program guidelines.

### ***Eligibility***

- Patient must have evidence of the need to travel more than 50 miles from home to receive medical services for their epilepsy/seizure disorder. A letter from the patient's doctor, medical service provider, or the facility (i.e., hospital) where the services will be rendered is required. This letter should be on the doctor's or facility's letterhead and include the date(s) of treatment and reason for the visit (i.e., treatment received).
- Applicants must complete a "Request for Travel Assistance Application." (attached)
- Evidence must be provided that the applicant has attempted to exhaust at least *three* other funding sources available within the county and state where the patient lives, and from the insurance company with which the patient participates. "**Please note that if treatment is sought from a medical facility outside of your county or state---you will have to indicate why.**" This is a fund of last resort.
- Generally, the fund will assist the patient for his or her travel costs only, unless the applicant is a minor or extraordinary circumstances exist. If the applicant is a minor, funds may be approved for one adult to accompany the minor and/or one escort to accompany the client.
- Original receipts are required for reimbursement.

### ***Applicants from Areas Served by an Affiliate***

Applicants in affiliated areas must submit the application to the affiliate. The Affiliate will verify the information provided by the applicant, sign the application, and submit applications to the National Office on behalf of the patient.

### ***Applicants from Unserved (Unaffiliated) Areas***

Applicants from unserved areas will apply for assistance directly to the Epilepsy Foundation's National Office by completing a *Request for Travel Assistance Application*. An unserved area is one in which there is no state or local affiliate of the Epilepsy

Foundation. (If you are uncertain, please contact the Epilepsy Foundation at 1-800-470-1655 ext. 3732, or go to [www.epilepsyfoundation.org](http://www.epilepsyfoundation.org) and click on “About Us” and then click on “Local Affiliates” to locate an affiliate in your area.)

### ***Program Guidelines***

- The **maximum** amount which can be awarded per family within any 2-year time period is **\$2,000**. Most awards will be for less than \$1,000. An itemized list of expected expenses will help the applicant define the amount needed.
- Applications for reimbursement and original receipts must be submitted no later than 30 days following the date of the last day of travel. For example, if your trip takes place May 16<sup>th</sup> through May 19<sup>th</sup>, your local affiliate or the National office should have your application and receipts on or before June 19<sup>th</sup>.
- After initial submittal and notification of approval of an application, should an individual require further travel within a one year time period (from initial application), a request for additional funds may be made in the form of a supplemental letter. This letter must include date(s) of travel, reason for travel, and amount requested. Be sure to also note if any information relayed on original application has changed such as, address, income level, etc. Each individual request will be subject to review and there is no guarantee of approval for subsequent trips or that the fund will not be depleted.
- Reimbursement will only be provided for:

**Air, rail, bus fare or mileage between a patient’s United States residence and the facility where treatment is received. Lodging, parking and tolls, and up to \$30 allowance per day for reasonable meal expenses, only for approved travelers. Reimbursement will be provided for all approved expenses where original receipts have been submitted.**

Expenses for treatment/medical services that are not specifically for the patient’s epilepsy/seizure disorder will not be considered.

Expenses that will not be approved include, but are not limited to:

- 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

### *Selection Process*

- A committee of three members will review each request. The committee will consist 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.
- All Requests for Penry Fund travel assistance must be made through Mary Ann Thornton at the National Office (800/470-1655, ext. 3732; mthornton@efa.org). **Applicants in affiliated areas must submit the application through the affiliate.**

**J. KIFFIN PENRY PATIENT TRAVEL ASSISTANCE FUND  
REQUEST FOR TRAVEL ASSISTANCE APPLICATION**

Applicant: \_\_\_\_\_ Age: \_\_\_\_\_  
(person with epilepsy)

Parent/Guardian \_\_\_\_\_  
(if applicant is a minor)

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: daytime \_\_\_\_\_ evening \_\_\_\_\_

Email: \_\_\_\_\_  
(if applicable)

Please list your current household **annual** income from **all sources** for each adult who lives in your household. Please include child support, public assistance, housing supplements, disability payments, SSI, etc. \$ \_\_\_\_\_/year

How many people in your household are supported by the above income? \_\_\_\_\_

What amount of medical costs for epilepsy/seizure disorder does your insurance cover? \_\_\_\_\_%

Have you submitted travel expenses to your insurance company? Yes No

Do you and/or your child receive SSI or Medicaid? Yes No

Please list what resources you have contacted for travel assistance and what their responses have been: (i.e., local church, Lion's Club, local Social Services office, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Who will be traveling with the patient on this trip? \_\_\_\_\_

Are you receiving financial assistance from any other source to allow you to travel for medical services? Yes No

**If yes, please name other source(s):**

**Expected date(s) of Travel** \_\_\_\_\_

**Travel Location** \_\_\_\_\_

(include name of facility, city and state)

**Please itemize your expected expenses below:**

Primary mode of travel – (Air, rail, bus fare, mileage, etc.) \$ \_\_\_\_\_

Please indicate the anticipated number of miles \_\_\_\_\_

*Mileage can be calculated by multiplying the anticipated miles by .55*

Lodging (Indicate total expected cost) \$ \_\_\_\_\_

Meals - Up to \$30 allowance per day for reasonable expenses \$ \_\_\_\_\_

List number of days: \_\_\_\_\_

Parking, cab fare, other unusual expenses \$ \_\_\_\_\_

**Grand Total** \$ \_\_\_\_\_

***Actual (original) receipts must be provided for all expenses (except mileage) for reimbursement.***

The **maximum** amount which can be awarded per family within any 2-year time period is **\$2,000**. The Penry fund will consider one trip at a time for an applicant, but multiple requests may be made totaling **\$2,000** over a two year period, as long as the fund has adequate resources.

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Please 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.)

Have there been any recent, unusual expenses? (Please explain.)

Special Family Circumstances: (Please use another sheet if necessary.)

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I declare that the information provided on this application for financial assistance is true and complete and is provided to the Epilepsy Foundation for the purpose of being considered for financial assistance to enable me to travel to obtain medical services. I understand that I may be required to provide evidence to verify the above information. I further give my permission for the Epilepsy Foundation to contact the affiliate staff and/or medical professional, for the purpose of verifying this information.

I agree \_\_\_\_/do not agree \_\_\_\_ to the Epilepsy Foundation's use of my name in announcing Travel Awards and related publicity concerning this program.

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Signature of Applicant or Parent/Guardian

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Date

**Required Attachment: Letter from health care provider or facility where the services will be rendered.**

**Affiliate Statement**

I hereby affirm that I have reviewed this application and am in full support of this request for travel assistance.

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Signature of Affiliate Staff (if applicable)

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Date

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Affiliate Name

*Please submit application to your local Epilepsy Foundation affiliate. If from an unserved area, submit application to Epilepsy Foundation National Office.*



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