Patient Assistance Fund

The Epilepsy Therapy Project (ETP) has developed this program to provide financial assistance to individuals with limited financial resources who have been accepted for enrollment in any IRB-approved clinical trial of an epilepsy therapy and who has signed an informed consent form for the trial. Funding will be made available to help cover out-of-pocket costs associated with participation in these clinical trials. Eligible expenses for reimbursement will include travel expenses to the study site and co-payments, deductibles, and co-insurance required by the patient's health plan.

Eligibility

- Applicants must complete a "Request for Financial Assistance Application" that includes information about the applicant's financial resources available to support clinical trial participation.
- The principal investigator of the applicable clinical trial must sign the application in order to verify that the patient has been accepted into the clinical trial and has given informed consent in accordance with the approved study protocol.
- The Epilepsy Therapy Project will evaluate the applicant's financial need in accordance with ETP guidelines. Generally, eligible individuals will have net income that does not exceed 300% of the federal poverty level. Unusual circumstances may be considered in determining eligibility.
- Generally, the fund will assist the patient with his or her own participation-related expenses only.
- Original receipts (e.g., Explanation of Benefits from health plan; travel expense receipts) are required for reimbursement of expenses.

Program Guidelines

- The maximum amount that will be awarded per individual will be $5,000 per two-year period.
- Reimbursement will be provided only for the patient's out-of-pocket costs that are not covered by his or her health insurance, Medicare, Medicaid, other federal or state assistance program, or the study sponsor as detailed in the clinical trial's informed consent form. These expenses are anticipated to include co-payments, deductibles, co-insurance, and travel expenses.
- Funds will be awarded to eligible individuals on a first come, first-served basis to the extent that funding is available. Donors to the Patient Assistance Fund or persons related to donors will not receive preferential treatment.
- After an applicant has been notified of his or her acceptance for financial assistance, eligible expenses may be submitted for reimbursement by completing a "Request for Reimbursement of Expenses" form and sending the form along with original receipts to the address below. It is not necessary to complete a new application each time that reimbursement is requested within the two-year award period.
- The following travel expenses will be eligible for reimbursement:

  Air, rail, or bus fare or mileage; lodging; parking and tolls; up to $30 per day for reasonable meal expenses.
- Applications and requests for reimbursement may be submitted to:

Epilepsy Therapy Project
Attn: Patient Assistance Fund
P.O. Box 742
Middleburg, VA 20118
(540) 687-8066 (fax)

For additional information about this program, please call: (540) 687-8077

Patient Assistance Fund

REQUEST FOR FINANCIAL ASSISTANCE APPLICATION

Applicant: ______________________________

Sponsor[1]: ______________________________

Address: ______________________________

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Phone: daytime______________________evening______________________

Email: ______________________________

Please provide the following information about the epilepsy clinical trial that you are currently enrolled in.

Name of Clinical Trial: ______________________________

Epilepsy Therapy Being Investigated: ______________________________

Anticipated Period of Study Participation: ______________________________

Medical Institution: ______________________________

Address: ______________________________

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Please provide the following financial information so your eligibility for this program can be determined. Attach a copy of Applicant/Sponsor's most recent federal income tax return.

Annual **taxable income** (from Line 42 of most recent federal income tax return of Applicant or Sponsor)	**$**
Less: **Federal income tax** (from Line 62 of most recent federal income tax return of Applicant or Sponsor)	**$**
Total annual net income	**$**

[1] Financially responsible party if other than applicant

Patient Assistance Fund

REQUEST FOR FINANCIAL ASSISTANCE APPLICATION

Please list any special circumstances that you would like us to consider in determining your eligibility.

Patient Assistance Fund

I certify that the information provided on this application for financial assistance is true, correct and complete. I further certify that it is provided to The Epilepsy Therapy Project for the purpose of consideration for financial assistance for the Applicant's participation in an epilepsy therapy clinical trial. I give my permission for The Epilepsy Therapy Project to contact the medical professional or institution named in this application for the purpose of verifying this information.

____ ______________________

Signature of Applicant or Sponsor Date

I certify that the applicant is currently enrolled in the epilepsy therapy clinical trial named in this application and has given informed consent in accordance with all applicable requirements of my institution's Institutional Review Board, and that the clinical trial does / does not (please circle one) provide financial assistance to the applicant.

____ ______________________

Signature of Principal Investigator Date

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Print Name of Principal Investigator

Institution: ____________________________________

Phone: ______________________________________

Please submit application to:

Epilepsy Therapy Project
Attn: Patient Assistance Fund
P.O. Box 742
Middleburg, VA 20118

540.687.8066 (fax)

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Patient Assistance Fund

REQUEST FOR REIMBURSEMENT OF EXPENSES

Patient Name: ____ Date: _______________

A. Insurance Co-pays, Deductibles, and Co-Insurance

Date of Medical Service	Description of Medical Service	Co-pay, Deductible, or Co-Insurance
Reimbursement Requested		$

Original receipts must be provided (e.g., Explanation of Benefits from insurance company / health benefit plan).

B. Travel Expenses

Date of Travel for Medical Services	Type of Travel Expense	Amount of Travel Expense
Less: Reimbursement / Travel stipend provided by clinical trial (if any)		
Reimbursement Requested		$

Original receipts must be provided (except for mileage which may be included at $0.40 per mile).

For additional information about this program, please call: (540) 687-8077