



## About The Fund

Maria Lutz is a 17 year old girl from Hamilton County who was diagnosed with epilepsy at the age of X. Maria knows how important it is for people with epilepsy to take their medication. She can't imagine being in a position where she couldn't afford her prescriptions, and she wants to make sure that no one else is in this position either. A few years ago, Maria was nominated to receive a Wish from Make A Wish Foundation of Northeastern New York. Maria chose to use her Wish as a Give Back Wish, and has used the money to create a fund with the Epilepsy Foundation of Northeastern New York that will help people with epilepsy pay for their medication.

## Eligibility Criteria – Who can apply?

Individuals must have a confirmed diagnosis of epilepsy. Please provide documentation from your doctor that states your name and diagnosis. This can be a picture of your current seizure prescription.

Individual must reside in one of the twenty-two counties covered by the Epilepsy Foundation of Northeastern New York. These counties include: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren and Washington.

## What The Fund Will Consider

In most cases the fund will only consider requests which cannot be reimbursed by other sources. The committee will only consider one request per family per year except for urgent or emergency circumstances. Families requesting funds for the first time may be given preference, again depending on the circumstances of the request. Typically, the fund will cover up to a 30 day supply, not to exceed \$250. This fund is intended to be a bridge until insurance is approved or the individual can access a patient assistance program. The staff of the Epilepsy Foundation of NENY will assist you to develop a long-term plan. Individual must have a refill available at their local pharmacy.

# APPLICATION FORM

Today's Date: \_\_\_\_\_

Have you ever contacted the Epilepsy Foundation of Northeastern New York? \_\_\_\_\_

How did you hear about this fund? \_\_\_\_\_

First Name of Applicant: \_\_\_\_\_

Last Name of Applicant: \_\_\_\_\_

Applicant's Date of Birth: \_\_\_\_\_

If applicant is a minor, name of parent or guardian: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

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

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Doctor's Phone Number: \_\_\_\_\_

Type of Seizures: \_\_\_\_\_

Name and dosage of medication you are requesting: \_\_\_\_\_

Name of your Pharmacy: \_\_\_\_\_

Address of your Pharmacy: \_\_\_\_\_

Phone Number of your Pharmacy: \_\_\_\_\_

Briefly describe your situation and why you are requesting financial assistance to pay for your medications:

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I certify that the information provided on this application is true and complete without consequential omissions of any kind. I understand and agree that any misleading or incorrect statements or omissions may render this application void. I have read, understand, and by my signature consent to these statements.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Epilepsy Foundation of Northeastern New York, Inc.  
3 Washington Square  
Albany, NY 12205  
(518) 456-7501  
Fax: (518) 452-1282

FOR EFNENY Staff Use Only
Was this request approved? _____
Staff Approval: _____
Executive Approval: _____
Notes: _____ _____
Amount approved: _____
Method of payment: _____