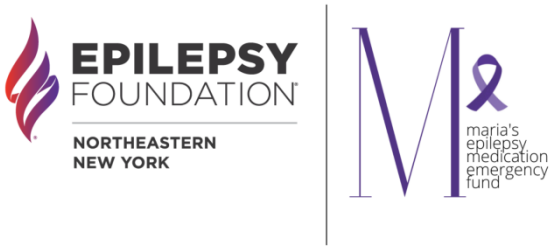

About The Fund

Maria Lutz is a 17 year old girl from Hamilton County who was diagnosed with epilepsy at the age of 12. 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:

_____
_____
_____
_____
_____

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: _____