EPILEPSY FOUNDATION
NORTHEASTERN NEW YORK

North Country Medical Travel Reimbursement Application

The Epilepsy Foundation of Northeastern New York is pleased to offer a fund to reimburse families who must travel a distance from home to seek medical care and/or treatment for their family member who has epilepsy, and lack adequate financial resources for the cost of this travel.

Grants will be reviewed by a committee and grants will be awarded following these meetings. Please complete all sections.

Section A: Personal Information

To be completed by parent or legal guardian. Please provide all personal contact information. Provide a brief description of the medical treatment along with an explanation of why it is necessary to travel outside your home locale. If necessary, attach a separate sheet with your explanation.

Section B: Medical Treatment / Services Information

List the name of the facility you will be traveling to and include the facility address and telephone number.

*A post appointment letter or complete discharge notes from the treating doctor indicating reason(s) for treatment and treatment dates is **REQUIRED**. Attach this letter as part of your application.*

Section C: Travel Information

Provide beginning and ending date(s). Complete all necessary columns on the expense worksheet. Please note the following:

1. **MILEAGE:** Mileage is paid at .40 per mile. To receive reimbursement for tolls or parking, you must submit a receipt. We do **NOT** reimburse for gas.
2. **LODGING:** Lodging is paid at the rate of up to $150/night. Please submit lodging receipt for verification.
3. **MEALS:** Meals are reimbursed at the rate of up to $50/day for the day **OF** appointment only, or the duration of an inpatient hospital stay. Receipts are required.

- ***If travel is via bus or train, please submit receipts which indicate that tickets have been paid.***

Section D: Disclosure/Signature

Date and sign the application. Application must be signed and dated by the patient or parent / guardian and also your neurologist or primary care physician.

Incomplete applications will result in a delay or denial.

Epilepsy Foundation of Northeastern New York 3 Washington Square Albany, NY 12205
518.456.7501 l FAX: 518.452.1285
epilepsy.com/northeastern-new-york

Section A: Personal Information

Name of Individual Receiving Treatment : _____ DOB: _____

Parent /Guardian (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone #: _____ Evening phone #: _____

Email Address (**REQUIRED)**: _____

Describe your medical condition and the treatment you are seeking. Include why it is necessary to travel away from your home to seek treatment/services. If follow-up care at this facility will be necessary please include when and why. Please use additional paper if necessary.

_____
_____
_____
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_____

Section B: Medical Treatment / Services Information

Doctor and Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Section C: Travel Information

Please fill out the attached Expense Worksheet COMPLETELY. This includes totaling all appropriate columns.
Applications will not be reviewed if this sheet is not filled out.

Section D: Disclosure/Signature

I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge. I understand that what I submit to the Epilepsy Foundation of Northeastern New York is for the purpose of financial reimbursement to enable travel for medical treatment/services.
I understand that I may be required to provide additional evidence of submitted information and I give permission to the Epilepsy Foundation of Northeastern New York to contact the medical facility for verification purposes.

I agree to allow the Epilepsy Foundation of Northeastern New York to use my name in announcements and related publications. _____ Yes _____ No

Signature of Applicant or Parent/Guardian: _____
Printed name of Applicant or Parent/Guardian: _____

Signature of neurologist or primary care doctor: _____
Printed name of neurologist or primary care doctor: _____
Contact number: _____ Date: _____

Application Checklist:

Please make sure to include the following:

[ ] Complete, signed application
[ ] Medical letter from doctor on medical facility letterhead stating medical necessity.
[ ] Complete expense worksheet
[ ] Required receipts for travel reimbursement
[ ] Discharge notes or post appointment letter
Total amount requested: $ _____

North Country Medical Travel Expense Worksheet

PLEASE FILL OUT THIS FORM COMPLETELY OR APPLICATION WILL NOT BE REVIEWED

Name of Individual Receiving Treatment:

	Date	Date	Date	Date	Date	Date	Date	Date
Date MM/DD/YY								

								TOTAL
Mileage (.40/mile)								
Other Transportation	$	$	$	$	$	$	$	
Lodging up to $150/night	$	$	$	$	$	$	$	
Meals up to $50/day per family	$	$	$	$	$	$	$	
Total per Day	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**

Please attach receipts for expenses listed above. Reimbursement check should be made payable to:
_____

Comments or Other Information:
_____
_____
_____