



## J. KIFFIN PENRY PATIENT TRAVEL ASSISTANCE FUND

### Request for Travel Assistance Application Criteria for Eligibility and Program Guidelines

*The Epilepsy Foundation is able to provide this program  
through a generous gift from Cyberonics, Inc.*

**Effective February 19, 2014**

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 (PAB) and National Board of Directors.

Travel scholarships are available to individuals who have had to travel more than 50 miles from their home to receive **FDA-approved medical care and/or treatment for their epilepsy/seizure disorder, but lack adequate financial resources to meet the cost of this travel without bearing financial hardship.** Eligibility and program guidelines are as follows:

#### **ELIGIBILITY**

- ♦ Applicants must be a United States citizen and must reside in the United States, Puerto Rico or US Virgin Islands.
- ♦ Applicants must attempt to exhaust **at least three** other funding sources within the county and state where the patient lives in addition to their insurance company.
- ♦ Applicants must provide justification for obtaining medical treatment/services more than 50 miles outside of the patient's home for their epilepsy/seizure disorder. Official documentation from the patient's doctor, medical practitioner, or facility where treatment/services will be provided is required and must include the reason(s) for treatment, treatments received, and date(s) of treatment.
- ♦ Applicants may apply prior to travel for pre-approval, but must provide **original** receipts for final application consideration and funds disbursement.

#### **APPLICANTS FROM AREAS SERVED BY AN AFFILIATE**

Applicants in Epilepsy Foundation Affiliate-served areas must submit the **Request for Travel Assistance Application** directly to the Affiliate. The Affiliate will review and verify the information provided by the applicant, sign the application, and forward it to [Mary Ann Thornton](mailto:MaryAnnThornton@efa.org) at the National Office (1-800-332-1000) or [mthornton@efa.org](mailto:mthornton@efa.org)) on behalf of the applicant.

#### **APPLICANTS FROM UNSERVED (UNAFFILIATED) AREAS**

Applicants from unserved areas (areas where there are no state or local Epilepsy Foundation Affiliates) must apply directly to the Epilepsy Foundation's National Office by completing a **Request for Travel Assistance Application.**

To locate any state or local Epilepsy Foundation Affiliates in a specific area, applicants can:

- ♦ Contact the Epilepsy Foundation at 1-800-332-1000 or
- ♦ Visit the Epilepsy Foundation's [Local Support](#) page at [www.epilepsy.com](http://www.epilepsy.com) to locate an affiliate in the area.

All Penry Fund Travel Assistance Applications from applicants in **unserved areas only** must be directly forwarded to [Mary Ann Thornton](#) at the National Office (1-800-332-1000) or [mthornton@efa.org](mailto:mthornton@efa.org).

#### **PROGRAM GUIDELINES**

- ♦ The **maximum** amount that can be awarded per individual within any 2-year time period is **\$1,500** and **\$3,000** per family. Family must have two (2) or more immediate family members in the same household diagnosed with epilepsy.
- ♦ Completed application packages must include original receipts and be submitted no later than 30 calendar days after the last day of travel. For example, if an applicant's travel spans May 16-19, the National office or Affiliate should receive a completed application package with receipts no later than June 19.
- ♦ Should an individual require further travel assistance within a two-year time period after the initial application submittal and notification of award, a request for additional funds may be made by submitting a Penry Supplemental Request Form. This request must be submitted within 30 calendar days after the last date of relevant travel and include date(s) of travel, reason(s) for travel, and the amount requested. Each individual request will be subject to review as there is no guarantee of subsequent trip approval or fund availability.
- ♦ Eligible expenses include:
  - Air, rail, bus fare or mileage between a patient's United States residence and the facility where treatment is received; and/or
  - Lodging/hotel, parking, cab fare and tolls for the individual receiving treatment and an adult companion/parent if the individual receiving treatment is a minor and/or cognitively unable to travel without adult supervision/assistance.
- ♦ Expenses for medical treatment/services not directly related to the patient's epilepsy/seizure disorder will not be considered.
- ♦ Expenses that will not be approved include, but are not limited to:
  - Meals
  - 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
- ♦ Scholarships are awarded on a first-come, first-serve basis until funds are exhausted during any given program year.

#### **SELECTION PROCESS**

A Review Committee will review each **Request for Travel Assistance Application**. The committee consists 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.

**Follow these steps to fill out the application - Please complete all Sections**

**Section A- Personal Information**

To be completed by patient or legal guardian. Please provide all personal contact information. Provide a brief description the medical treatment along with an explanation of why it is necessary to travel beyond 50 miles from your home. If necessary, attach a separate sheet with your explanation.

**Section B- Financial information**

Provide copy of your last federal tax return or social security income yearly benefits statement and any other source of income received during the last year. Please indicate the number of people supported by the listed income, the percentage of medical costs covered by your health insurance as well as deductible information. Indicate whether or not you have submitted travel expenditure documentation to your insurance company for reimbursement in addition to this application. Check the appropriate box to indicate if you or your child receives Medicaid.

**Section C-Resource Information**

You must have exhausted three other local community resources within the county and state where the patient lives. Please list three resources you have tried and the outcome (Granted or Denied). Resources can be, but are not limited to the local affiliate, local churches, Lion's Club, Social Services, a family member, United Way, Red Cross, etc. If granted, List the amount awarded and what the award is for (i.e. travel, food, lodging, etc.)

**Section D-Medical Treatment/Services Information**

List the name of the facility you will be traveling to and include the facility address and telephone number. **Get a letter from the doctor indicating reason(s) for treatment, treatment dates and whether treatment has already been received. Attach this letter as a part of your Penry application.**

**Section E-Travel Information**

Provide beginning and ending of travel date(s). Complete all expenses whether you take your personal vehicle, rent a car, air, rail or bus. **If you use your personal vehicle, you can calculate your mileage from your home at a rate of \$.30 per mile.** List any lodging/hotel, parking, cab and/or toll expenses in the appropriate block. **You must provide your original receipts with these expenses.**

**Section F-Disclosure/Signature**

Date and sign the application. Please indicate if the Epilepsy Foundation can use your name in Travel Assistance Fund Awards Announcements and related publications.

**Section G-Epilepsy Foundation/Affiliate Statement – For Staff Use Only**

This section contains the Affiliate Site Name, the name of the Foundation or Affiliate Staff member that accepted and reviewed the Penry Application as well as the date of the review and signature of the staff member.

Submit your completed package with supporting documents (doctor's letter and all original receipts) to your local Epilepsy Foundation Affiliate or directly to the Epilepsy Foundation's National Office if in an unserved area. **Please keep a copy of all information submitted for your records.**

**Incomplete applications can result in a delay or denial.**

**PENRY PATIENT TRAVEL ASSISTANCE FUND**  
**Request for Travel Assistance Application**  
**Please Print Clearly**

<b>Section A Personal Information</b>			
Applicant/Patient		Age	
Parent/Guardian (if applicable)			
Address			
City		State	
Zip Code			
Daytime Telephone		Evening Telephone	
E-Mail Address			
Briefly describe the medical treatment that is required at this time. Are these services available closer to home? <b>Please include why it is necessary to travel beyond 50 miles from your home</b> (attach another sheet if necessary).			
<b>Section B Financial Information</b>			
Please indicate your annual income as reported on your last Federal Tax Return. <b>Applicants must submit a copy of their last Federal Tax Return or Social Security Income yearly benefits statement.</b>	\$		
Please indicate any other income (including Public Assistance, Child Support, SSI Benefits, Long- or Short-Term Disability, etc.) received during the last year	\$		
How many people in your household are supported by the above income?			
What percentage of medical costs does your health insurance cover?	%		
How much is the deductible on your health insurance?	\$		
Have you submitted travel expenditure documentation to your insurance company for reimbursement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you and/or your child receive Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### Section C Resource Information

Please list any resources (local churches, Lion's Club, Social Services, etc.) you have contacted to request/obtain travel assistance and the outcome. If granted, list the amount awarded and what the award is for (i.e. travel, food, lodging, etc.)

(1)		<input type="checkbox"/> Granted	<input type="checkbox"/> Denied
(2)		<input type="checkbox"/> Granted	<input type="checkbox"/> Denied
(3)		<input type="checkbox"/> Granted	<input type="checkbox"/> Denied
Do you expect to receive any additional financial assistance from any other sources to accommodate travel for medical treatment/services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

(If yes, please specify other sources)

(1)	
(2)	
(3)	

### Section D Medical Treatment/Services Information

Practitioner/ Facility Name			
Address			
City		State	
Zip Code			
Telephone			

### Section E Travel Information

Start Date		End Date	
------------	--	----------	--

Please itemize your expenses below

**Original receipts of all expenses (except mileage) must be provided to receive reimbursement.**

Cost of Primary Travel Mode (air, rail, bus, personal automobile, etc.)	\$
If using a personal automobile please provide an estimate of miles to be travelled (Mileage will be compensated for at the rate of \$0.30/mile).	
Lodging/Hotel	\$
Parking, cab fare, other unusual expenses (please explain )	\$
TOTAL	\$

**Section F Disclosure/Signature**

I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge and is being provided to the Epilepsy Foundation for the purpose of receiving financial assistance consideration to enable travel for medical services. I understand that the maximum amount which can be awarded per individual within any two-year period is \$1,500 and \$3,000 per family. The Penry Fund will consider one trip at a time for an applicant; however multiple requests can be made over a two-year period totaling \$1,500 for an individual and \$3,000 for a family as long as the Fund has adequate resources.

I further understand that I may be required to provide evidence of the submitted information, and authorize the Epilepsy Foundation to contact the appropriate Affiliate staff and/or medical practitioners for verification purposes.

(Check One) I agree /do not agree  to allow the Epilepsy Foundation to use my name in Travel Assistance Fund Awards Announcements and related publications.

Signature of Applicant or Parent/Guardian	
Date	

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



**Section G Epilepsy Foundation/Affiliate Statement**

**STAFF USE ONLY**

I hereby affirm that I have reviewed this application along with the required supporting documentation and am in full support of this request for travel assistance.

Name of Epilepsy Foundation/ Affiliate Representative	
Signature of Epilepsy Foundation/ Affiliate Representative	
Affiliate Site Name (if applicable)	
Date	

*Please submit completed application package with supporting documents to your local Epilepsy Foundation Affiliate. Applications submitted directly to the Epilepsy Foundation National Office is only accepted if the applicant resides in an unserved area. It is strongly recommended that you keep a copy of this application package for your files.*

# PENRY PATIENT TRAVEL ASSISTANCE FUND CHECKLIST

## Applicant Checklist

- Copy of Penry Application with all sections filled out completely.
  - Section A – Personal Information
  - Section B – Financial Information
  - Section C – Resource Information
  - Section D – Medical Treatment/Services Information
  - Section E – Travel Information
  - Section F – Disclosure/Signature
- Copy of federal tax return/social security income yearly benefits statement
- Medical Documentation (letter from doctor)
- Original Expenditure Receipts
  - Travel (Air, Train, Bus or Automobile)
  - Lodging/Hotel, cab fare and tolls

## Affiliate Checklist

### For National Office/Affiliate Representative Use Only

- All Sections of the Application are filled out completely.
  - Section A – Personal Information
  - Section B – Financial Information
  - Section C – Resource Information
  - Section D – Medical Treatment/Services Information
  - Section E – Travel Information
  - Section F – Disclosure/Signature
- Copy of federal tax return/social security income yearly benefits statement is attached
- Medical Documentation (letter from doctor) is attached
- Original Expenditure Receipts are included
  - Travel (Air, Train, Bus or Automobile)
  - Lodging/Hotel, cab fare and tolls
- Applicant has signed the application.
- Affiliate/Foundation Staff has completed Section G – Epilepsy Foundation/Affiliate Statement

**Attach original receipts**