



## Maria's 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. This fund was made possible by Maria Lutz, a young woman from Hamilton County who was diagnosed with epilepsy at the age of 12. When Maria was 17, she was nominated to receive a Wish from Make-A-Wish Foundation of Northeast 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 to help people with epilepsy.

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 the beginning and ending date(s). Complete all necessary columns on the expense worksheet. Please note in 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 \$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.**

**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: \$ \_\_\_\_\_

**Maria's 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	\$	\$	\$	\$	\$	\$	\$	
<b>Total per Day</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

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

\_\_\_\_\_

Comments or Other Information:

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\_\_\_\_\_  
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