Halyn Murtha was a vibrant, young girl whose life was cut short as a result of SUDEP (Sudden Unexplained Death in Epilepsy). The Murtha Family and the Epilepsy Foundation of Connecticut are pleased to offer this assistance fund, which has been created in her honor. This fund is to help people with epilepsy in need of financial assistance to cover the cost of epilepsy treatment, and care services associated with the condition.

The Epilepsy Foundation of Connecticut (EFCT) is a Section 501(c)(3) not for profit organization that is leading the fight to overcome the challenges of living with epilepsy and accelerating therapies to stop seizures, find cures and save lives.

The Halyn Murtha Family Assistance Fund will provide financial assistance for qualified services, tangible goods or supports recommended by an applicant's neurologist and not available/supported through private medical insurance, a government program (such as Medicare, Medicaid, etc.) or other sources. The following are examples of qualified services or items:

- Medication Assistance
- Medical Services, Devices or Supports
- Respite Care Services

Eligibility Criteria:

To be eligible, the applicant must:

- Currently be under the care of a licensed neurologist or epileptologist
- Certify medical need
- Submit a completed and executed application for financial assistance, along with any required documentation.
- Be able to identify and explain the purpose of the request for financial assistance, including a statement of need

Funds Availability:

Grants are awarded at the discretion of the Fund committee and subject to the availability of fund resources and application requirements. **EFCT does not pay personal expenses such as utilities, car payments, rent, etc. If an application for financial assistance is approved, payment will be made directly to the creditor/vendor. As funds are limited, EFCT encourages all applicants to create a plan for additional support and assistance, and to contact additional community services.**

Epilepsy Foundation of CT
860.346.1924

EPILEPSY FOUNDATION
Connecticut

386 Main St. Middletown CT 06457
www.epilepsyct.com

How to Apply:

Complete the attached application with all required signatures along with the appendix section for which you are applying ONLY.

Include any additional documentation required per the appendix section.

Each application will be reviewed by a family assistance fund committee. It may take up to 21 days for applicants to receive a response to their request. Submission of an application does not guarantee an award will be made

Only fully completed and executed applications will be reviewed and considered.

Please submit completed application:

Scan and e-mail to monica@epilepsyct.com

-OR-

Mail to:
Monica Anzelone
Epilepsy Foundation of Connecticut
386 Main Street, Middletown, CT 06457.

-OR-
Fax to 860-346-1928

For any additional questions, please contact Monica at 860-346-1924 or monica@epilepsyct.com.

Application

Date: _____

Patient Last Name		**First Name**	

Street Address			**Apartment/Unit #**		
City		**State**		**Zip**	
Phone		**Email Address**			

Name of Health Insurance coverage			
If not patient, name of person completing the application			
Relationship to patient		**Email & phone**	
Address *(if different from above)*			

Financial Assistance Requested

Amount of Funding Requested	**$**	**Purpose of requested funds**	
Name of vendor providing product or service			
	Address:		
Vendor Phone #		**Name of product or service applicant is purchasing**	

Has this request been submitted to or determined to be ineligible for coverage or reimbursement from insurance? Yes No

What other organizations have you applied for financial assistance?

_____

_____

Are you now or will you be receiving assistance from another organization? Yes No

If yes, please provide details and amount: _____

Certification

The undersigned agrees to the eligibility requirements of the Halyn Murtha Family Assistance Fund and confirms he/she does not have sufficient resources to pay for the qualified service/item

By signing below, you confirm the following:

- Special circumstances exist that require financial assistance not available from any other source.
- Patient or guardian does not have or has insufficient coverage for qualified service item through private insurance or government-funded programs, including Medicaid or Medicare.
- Patient has insufficient income due to being unemployed, underemployed, disability or other hardship.
- Patient has no other resources or means to pay for the qualified service/item

The undersigned certify and acknowledge to the Epilepsy Foundation of CT: the undersigned are acting on behalf of and are an advocate for the patient, no portion of the financial assistance will be used for administrative purposes, the patients request for financial assistance is a qualified service/item. The undersigned further certify that:

- The qualified service/item is necessary for the patient to monitor, control and/or reduce seizures.
- The Epilepsy Foundation of CT does not warrant or endorse any qualified service/item requested by the undersigned for the benefit of the patient.
- The Epilepsy Foundation of CT is not the provider, manufacturer, distributer, agent, affiliate, owner, representative or consultant for any provider of a qualified service/item.

- If approved, The Epilepsy Foundation of CT only provides financial assistance, in whole or part, for a qualified service/ item. The undersigned assume the sole responsibility to and did communicate directly and consult with the provider of the qualified service/item and patients attending physician, to determine that the purpose and use of the qualified service/item will be a benefit to and be in the best interest of the patient.
- The Epilepsy Foundation of CT has no responsibility or liability to or for the patient's use or benefit of the qualified service/item. The undersigned assume all risks and consequences from the use of the qualified service/item and release the Epilepsy Foundation of CT and its board of directors, sponsors, employees, volunteers, donors, and affiliates from any responsibility and liability, of any kind or nature, whether foreseen or unforeseen, relating to a patient's use of or benefit received (or not) from the qualified service/item.
- Approval for financial assistance is granted on an as needed basis and distributed only for the benefit of the patient.
- Payments are made directly to service provider. Certain exceptions may apply.
- The Epilepsy Foundation of CT reserves the right to approve or disapprove any request for assistance in whole or in part.

General Release

I/we understand that our participation with the Epilepsy Foundation of CT Halyn Murtha Financial Assistance Fund is voluntary and that these benefits are a humanitarian endeavor to provide financial support to patients who are affected by epilepsy or other seizure disorder and who are experiencing financial difficulties.

Your signatures below indicate that all the information provided in this application is true, correct, and complete.

Patient Signature: _____

Print Name: _____

Parent/Guardian Signature: _____

Print Name: _____

Appendices: Please only complete the section for which you are applying for assistance.

A. Medication Assistance

Patient Name: _____

Name of Medication to be filled: _____

Do you have prescription drug coverage for this medication?

Yes **No**

Explanation of Financial Need: _____

_____

_____

In most cases we will only be able to cover payment for one medication refill. What is your plan for coverage after this one-time payment?

_____

_____

_____

Physicians Name:_____

Physicians Contact Info:_____

Required Attachment: Please attach a copy of physicians' prescription for the above medication with this application.

B. Medical Services

Patient Name: _____

Explanation of Medical Necessity: _____

_____

Item/Device to be Purchased: _____

OR

Procedure Ordered by Doctor (not covered by Insurance): _____

_____

Physician's Name: _____

Physician's Contact Info: _____

Required Attachment: Please attach a copy of physician's prescription/order for device or procedure.

C. Respite

*Respite services involve short term or temporary **care** of patient for a few hours or weeks, designed to provide relief to the regular caregiver.*

Patient Name: _____

Parent or Care Giver Name: _____

Does the individual you are applying for care for receive the following?

Social Security Income: **Yes** **No**

Katie Beckett Waiver: **Yes** **No**

Department of Developmental Services (DDS): **Yes** **No**

Please list other sources of financial support: _____

_____

Does patient live with you?_____

Does patient attend a day program?_____

Is the Patient Employed?_____

Please describe the type of respite service needed?

_____

_____

_____