PATIENT ASSISTANCE
POLICY GUIDELINES & APPLICATION

The JoshProvides Epilepsy Assistance Foundation is a 501(c)(3) public, nonprofit organization which offers services and financial assistance to individuals whose physician has diagnosed them with epilepsy or other seizure disorder. The Foundation strives to relieve qualified patients of financial stress for treatment, technology, services, or devices that are recommended by the applicant's neurologist and when coverage is not available through private medical insurance, a government program (such as Medicare, Medicaid, etc.), another foundation, or a pharmaceutical company. The following are examples of Qualified Service Items with which we may assist:

- Seizure detection devices
- Prescription anti-seizure medications
- Transportation to and from home, school, medical services, or employment
- Seizure response dogs
- Genetic testing
- Epilepsy Research

In addition, JoshProvides will help develop and maintain support groups in areas where there are no existing or available support groups and will support epilepsy-related education for the general public.

Qualifications:
In order to qualify, the applicant must:

- Be currently under the care of a licensed neurologist or epileptologist
- Be able to demonstrate financial need
- Submit a completed application along with any required documentation
- Be able to clearly explain the amount and purpose of the request for financial assistance

Funds Availability
Grants are approved when JoshProvides has the funds to support the requested needs and the request is for an expense that falls into our priority funding areas listed above. The Foundation reserves the right to suspend grant allocations based upon resources available.

JoshProvides does not pay personal expenses such as utilities, car payments, rent, etc. If an application for assistance is approved, payment will be made directly to the creditor/vendor. As funds are limited, JoshProvides encourages all patients to create a plan for longer term support and assistance, and to contact additional community resources.

How to Apply
Complete the attached application, include any required documentation, scan and email to info@joshprovides.org or mail to 5428 Sundew Drive, Sarasota, FL 34238. For any additional questions, please contact JoshProvides at 800-706-2740 or info@joshprovides.org. Please allow *14* days for application review and payment processing.

APPLICATION FOR FINANCIAL ASSISTANCE

Only fully-completed applications will be accepted and considered.

APPLICANT INFORMATION							
Date of Application							
Patient Last Name		First Name					
Street Address					Apartment/Unit #		
City		State			ZIP		
Phone		Email Address					
Patient Date of Birth							
If not the patient, name of person completing application							
Relationship to Applicant		Email Address			Phone		
If not parent/guardian, name and address of organization acting on behalf of patient							
How did you find JoshProvides?							

FINANCIAL ASSISTANCE REQUESTED							
Amount of funding requested	$	Purpose of requested funds					
Name of vendor providing product or service							
Contact Name		Contact Email Address					
Vendor Address		City		State		Zip	
Vendor Phone #		Name of product or service applicant is purchasing					

To what other organizations have you applied for financial assistance? _____

Are you now or will you be receiving assistance from another organization(s)? YES ☐ NO ☐

If YES, provide details and amount: _____

JoshProvides Epilepsy Assistance Foundation
5428 Sundew Drive I Sarasota, FL 34238
www.JoshProvides.org I 800-706-2740

JoshProvides is a public, nonprofit 501(c)(3) and strives to be fiscally responsible with the donated dollars received from those who support the organization and its mission. JoshProvides considers financial assistance for those applicants who have a true financial need.

The undersigned and patient certify patient does not have sufficient resources to pay for the Qualified Service/Item:

- Patient has special circumstances that require financial assistance not available from any other source.
- Patient does not have or has insufficient coverage for Qualified Service/Item through private insurance or government-funded programs, including Medicaid benefits or Medicare Part D.
- Patient has insufficient income due to being unemployed, suffering from a severe loss of income, or a lack of income.
- Patient has no other resources or means to pay for the patient's Qualified Service/Item.

The undersigned certify that the requested Qualified Service/Item is necessary in order to monitor, control, or reduce seizures.

To be considered for a grant from JoshProvides, you will need to submit the following:

- This application, completed in its entirety and signed
- A picture of the applicant
- The attached signed Certification
- The attached signed General Release
- Appendix A, B, C, D, or E (A for a monitor or other technology, B for a seizure response dog, or C for transportation assistance, D for medical services, or E for anti-seizure medication), signed by the applicant's physician and completed in its entirety

Your signature below indicates that all of the information provided in this application is true, correct, and accurate.

Signature: _____ ☐ Self (over 18) ☐ Parent/Guardian

Print Name: _____

Date: _____

Certification

The undersigned certify to the Foundation that no portion of the funds will be used for administrative purposes.

The undersigned certify and acknowledge to the Foundation: 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 patient's request for financial assistance is a Qualified Service/Item and the financial assistance obtained will be used for a Qualified Service/Item. The undersigned further certify that:

- Foundation does not warrant or endorse any Qualified Service/Item requested by the undersigned for the benefit of patient;
- Foundation is not the provider, manufacturer, distributor, agent, affiliate, owner, representative or consultant for any provider of a Qualified Service/Item;
- If a Request is approved, Foundation only provides financial assistance, in whole or in 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 patient's 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 undersigned's Request for Financial Assistance is for a Qualified Service/Item;
- The undersigned have applied for a Qualified Service/Item after conducting their own due diligence regarding the use and benefit of the Qualified Service/Item for the patient without any endorsement or recommendation by Foundation; and
- Foundation has no responsibility or liability to or for the patient's use or the benefit of the Qualified Service/Item. The undersigned assume all risks and consequences from the use of the Qualified Service/Item and release the Foundation and its board of directors, officers, sponsors, agents, employees, volunteers, donors and affiliates from any responsibility and liability, of any kind or nature, whether foreseen or unforeseen, relating to patient's use of or benefit received (or not) from the Qualified Service/Item. Approvals for financial assistance are made on an as needed basis and distributed only for the benefit of the patient.

Foundation reserves the right to approve or disapprove any request for assistance in whole or in part.

The undersigned must provide a **photo of the patient** with this Request and hereby irrevocably consent to the Foundation's use of any and all photos and testimonials provided by the undersigned on its website or otherwise without any further obligation to secure the undersigned's consent. All additional documents attached to this Application are deemed incorporated herein by reference and made a part of this Application.

Signature: _____ ☐ Self (over 18) ☐ Parent/Guardian

Print Name: _____

Date: _____

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GENERAL RELEASE

I/We understand that our participation with JoshProvides 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.

IN CONSIDERATION OF RECEIVING FINANCIAL ASSISTANCE FROM THE FOUNDATION FOR THE RECEIPT OF A QUALIFIED SERVICE/ITEM, the undersigned, jointly and severally, represent and acknowledge (a) they have voluntarily requested the Foundation's assistance in acquiring a Qualified Service/Item and assume all risks and consequences from the use thereof, whether foreseen or unforeseen, including all liability, claims, losses, damages and injuries associated and/or incurred from the use of or failure to use the Qualified Service/Item, correctly or incorrectly; (b) Foundation only provided the financing for the Qualified Service/Item and the undersigned relied solely on patient's physician and the representatives of the provider of the Qualified Service/Item regarding the benefit to patient, patient's use and maintenance of the Qualified Service/Item and accepted the same from such provider on an "AS IS WHERE IS AND WITH ALL FAULTS BASIS" WITHOUT ANY WARRANTIES OF ANY KIND, EITHER EXPRESSED OR IMPLIED, FROM THE FOUNDATION; (c) on behalf of themselves, their personal representatives, heirs, successors and assigns, release and indemnify, defend, save, pay and hold harmless the Foundation, its board of directors, officers, sponsors, agents, employees, volunteers, donors, founders and affiliates from any and all liability, costs, losses, damages (including actual, special, consequential and lost profits), expenses, claims, and actions, whether at law or equity, regarding any and all injuries, loss of life, or disability to persons or property (collectively the "Losses"), no matter who is responsible for the Losses or who incurs the Losses; and (d) they have had the right to consult an attorney regarding their execution of this Application and have either done so or waived their right to do so before signing this Application.

The undersigned signatories certify to the Foundation each of the statements in this Application are true, correct and accurate and acknowledge that the Foundation will be relying on their certification in evaluating whether it will approve or disapprove the undersigned's request for financial assistance from the Foundation.

Signature: _____ ☐ Self (over 18) ☐ Parent/Guardian

Print Name: _____

Date: _____

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Appendix A:
Certificate of Medical Necessity for Seizure Monitor or Other Technology

This information must be completed in its entirety by the patient's physician.

Patient Name: _____

Diagnosis (Include an explanation of the particular problem resulting from the diagnosis that relates to this application for financial assistance): _____

_____

Explanation of Medical Necessity: _____

_____

Item being purchased: _____

Explanation of item's function: _____

Healthcare Provider's Office/Group Name: _____

Office Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

Appendix B:
Certificate of Medical Necessity for Seizure Response Dog

The purchase and maintenance of a seizure response dog is a significant investment of time and money. JoshProvides does not endorse any seizure response dog trainers. It is very important that each applicant conducts their own research, finds a trainer that is trusted and has a strong history of producing well-trained seizure dogs, understands the amount of time it will take to have a dog appropriately trained, understands the cost of total cost of ownership of a seizure response dog, and is willing to commit to fundraising for the amount of money that will be due to the trainer.

This section must be completed by the patient's physician:

Patient Name: _____

Diagnosis (Include an explanation of the particular problem resulting from the diagnosis that relates to this application for financial assistance): _____

_____

Explanation of Medical Necessity: _____

_____

Healthcare Provider's Office/Group Name: _____

Office Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

This section must be completed by the applicant:

Where will you be getting the dog that will be trained (a breeder, a shelter, the trainer, etc.)? Have you talked with a trainer and discussed the type of dog that can best be trained as a seizure response dog, the ideal age range for training, etc. prior to choosing a dog? _____

_____

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Who will be your dog's trainer: _____

Trainer's Address: _____
Trainer's Phone #: _____
Trainer's Email Address: _____
Trainer's Website Address: _____

How many years' experience does this trainer have specifically training seizure response dogs? _____

Have you checked the trainer's references, Googled them for reviews and information, and talked with at least two families who have used this trainer? Comments: _____

_____

_____

Are you satisfied? ☐ Yes ☐ No

Is the trainer a member of Assistance Dogs International (ADI)? ☐ Yes ☐ No

Did the trainer represent to you in writing that the trainer would abide by the ADI minimum standards of Assistance Dog Partners? ☐ Yes ☐ No

Did the trainer certify to you in your contract for training your dog that prior to the placement of your dog into service, your dog will:

- Meet the ADI standards and ethics? ☐ Yes ☐ No
- Be spayed/neutered? ☐ Yes ☐ No
- Receive all required vaccinations as required by their veterinarian and all applicable laws? ☐ Yes ☐ No
- Receive first class wellness and nurturing care and treatment by their licensed veterinarian? ☐ Yes ☐ No

Itemize, in detail, the total cost of training your dog, as quoted by your trainer (attach a copy of an invoice or estimate from the trainer).

_____

_____

_____

Upon completion of your dog's training, is your trainer registering your dog with the United States Service Dog Registry (USDR) and providing you with a certificate, ID card, service dog tag, service dog vest, service dog leash, and an electronic copy of the certificate and ID card from USDR? ☐ Yes ☐ No

What is the:

Total estimated cost of your dog: $_____
How much of the total cost of the purchase of your dog will you be paying? $_____
How much of the total cost of the purchase of your dog is another organization paying? $_____
How much money are you requesting from JoshProvides? $_____

Have you contacted any other agency for a grant to help purchase and train your dog? ☐ Yes ☐ No
If Yes, what other foundation or agency did you contact? _____

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How much funding have you requested from the other foundation/agency? $_____

Is the trainer a nonprofit organization or a for-profit organization? _____

If the seizure response dog is no longer needed for any reason, you acknowledge you will try and return the seizure response dog to the trainer to find another family in need of a dog. If the trainer is unable to take your dog, then you will deliver the dog to JoshProvides to give your dog to another family in need. This is a condition to JoshProvides for consideration of your grant request.

Signature: _____ ☐ Self (over 18) ☐ Parent/Guardian

Print Name: _____

Date: _____

Appendix C:
Application for Travel Assistance

JoshProvides will consider financial assistance for travel for applicants who are unable to drive due to epilepsy or another seizure disorder. The applicant will need to identify a method of transportation and include the transportation company and cost with this application.

This section must be completed by the patient's physician:

Patient Name: _____

Diagnosis (Include an explanation of the particular problem resulting from the diagnosis that relates to this application for financial assistance): _____

_____

Explanation of Medical Necessity: _____

_____

Healthcare Provider's Office/Group Name: _____

Office Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

This section must be completed by the applicant:

TRAVEL INFORMATION:

Purpose of Travel: _____

Start Date: _____ End Date: _____

Itemize your expenses below:

Cost of Primary Travel Mode (air, rail, bus, other): $_____

Parking, cab, other expense (explain with detail) $_____

TOTAL: $_____

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DISCLOSURE/SIGNATURE:

The undersigned declare that the information provided on this Travel Assistance Application is true, correct and complete to the best of our knowledge and is being provided to JoshProvides Epilepsy Assistance Foundation for the purpose of receiving financial assistance consideration to enable travel for medical services. We understand that JoshProvides Epilepsy Assistance Foundation will consider one request at a time for an applicant. All decisions by JoshProvides Epilepsy Assistance Foundation shall be final, made in whole or in part and in its sole and absolute discretion. We further understand that the undersigned and patient may be required to submit additional information, and we further authorize JoshProvides Epilepsy Assistance Foundation to contact the medical providers for verification purposes.

(Check One) I agree ☐/ do not agree ☐ to allow JoshProvides Epilepsy Assistance Foundation to use the patient's first name, testimonial and picture in announcements and related publications.

Signature: _____ ☐ **Self (over 18)** ☐ **Parent/Guardian**

Print Name: _____

Date: _____

REQUIRED ATTACHMENT: Letter from medical provider or facility where the services will be rendered acknowledging your services there.

Appendix D:
Certificate of Medical Necessity for Medical Services

This information must be completed by the patient's physician.

Patient Name: _____

Diagnosis (Include an explanation of the particular problem resulting from the diagnosis that relates to this application for financial assistance): _____

_____

Explanation of Medical Necessity: _____

_____

Medical Services to be provided: _____

Dates Medical Services are to be provided: _____

Office Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____

Appendix E:
Certificate of Medical Necessity for Anti-Seizure Medication

This information must be completed in its entirety by the patient's pharmacist. The amount for grants for anti-seizure medication is limited.

Patient Name: _____

Diagnosis (Include an explanation of the particular problem resulting from the diagnosis that relates to this application for financial assistance): _____

_____

Explanation of Medical Necessity: _____

_____

Anti-Seizure Medication to be Purchased (attach copy of prescription): _____

Pharmacy Name: _____

Pharmacy Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Pharmacist's Signature: _____ **Date:** _____

Pharmacist's Printed Name: _____