



**PATIENT ASSISTANCE  
POLICY GUIDELINES & APPLICATION  
MEDICAL SERVICES**

JoshProvides Epilepsy Assistance Foundation, Inc. is a Section 501(c)(3) public not for profit charity that offers services and financial assistance to individuals whose physician has diagnosed them with epilepsy or other seizure disorder. JoshProvides strives to relieve qualified and approved applicants from financial stress by providing financial assistance, in whole or in part, for assistance regarding Qualified Service/Items recommended by the applicant's neurologist and when such financial assistance is not available through private medical insurance, a government program (such as Medicare, Medicaid, etc.) or another foundation. The following are examples of Qualified Service/Items:

- Medical services
- Seizure alert & detection devices
- Seizure response dog
- Transportation & travel assistance

**Qualifications:**

In order to qualify, the applicant must:

- Currently be under the care of a licensed neurologist or epileptologist
- Certify financial need
- Submit a completed and executed application for financial assistance, along with any required documentation and a **picture of the applicant**
- 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. JoshProvides 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 financial assistance is approved, payment will be made directly to the creditor/vendor. As funds are limited, JoshProvides encourages all applicants to create a plan for additional support and assistance, and to contact additional community resources.***

**How to Apply**

Complete the attached application with all required signatures, (including any required additional documentation), scan and email it to [info@joshprovides.org](mailto:info@joshprovides.org) or mail to JoshProvides, 5428 Sundew Drive, Sarasota, FL 34238. For any additional questions, please contact JoshProvides at 800-706-2740 or [info@joshprovides.org](mailto:info@joshprovides.org). Please allow at least 21 days for review of your application for financial assistance. **Only fully completed and executed applications for financial assistance will be reviewed and considered. JoshProvides reserves the right to approve or deny an applicant's request for financial assistance, in whole or in part.**



**APPLICATION FOR FINANCIAL ASSISTANCE**  
**Only fully completed applications will be reviewed 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	
Name, address, email address and phone number of Medical Provider, Pharmacy, Referral Organization					
How did you find JoshProvides?					

**Your signatures below indicate that all of the information provided in this Application is true, correct, and complete.** The undersigned signatories certify to JoshProvides each of the statements in this Application are true, correct and accurate and acknowledge that JoshProvides will be relying on their certification in evaluating whether it will approve or disapprove the undersigned’s request for financial assistance from JoshProvides. The undersigned certify that the requested Qualified Service/Item is necessary in order to monitor, control, or reduce seizures.

**PATIENT:**

Signature: \_\_\_\_\_  Self (over 18)     Parent/Guardian  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL/HEALTH CARE PROVIDER:**

Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ NPI Provider #: \_\_\_\_\_  
 Date: \_\_\_\_\_

JoshProvides Epilepsy Assistance Foundation, Inc. – Medical Services Application

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: \_\_\_\_\_

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

- This application, completed in its entirety and signed by all required parties;
- A picture of the applicant; and
- Appendix D for medical services as identified and approved by neurologist

JoshProvides Epilepsy Assistance Foundation, Inc. (“JoshProvides”) is a Section 501(c)(3) public charity and strives to be fiscally responsible with the donated dollars received from those who support JoshProvides 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.

**Certification**

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

The undersigned certify and acknowledge to JoshProvides: 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:

- The Qualified Service/Item is necessary for the patient to monitor, control and/or reduce seizures;
- If applicable, patient has no means of transportation to and from home, school, work, or medical services without using public or private transportation;
- JoshProvides does not warrant or endorse any Qualified Service/Item requested by the undersigned for the benefit of patient;

- JoshProvides 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, JoshProvides 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 JoshProvides; and
- JoshProvides 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 JoshProvides 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.
- Payments are made directly to the creditor/vendor.
- JoshProvides 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 JoshProvides 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.

## 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 JoshProvides FOR THE RECEIPT OF A QUALIFIED SERVICE/ITEM**, the undersigned, jointly and severally, represent and acknowledge (a) they have voluntarily requested JoshProvides 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) JoshProvides 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 JoshProvides; (c) on behalf of themselves, their personal representatives, heirs, successors and assigns, release and indemnify, defend, save, pay and hold harmless JoshProvides, 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.

\_\_\_\_\_  
**Signature of applicant, or if a minor, parent/guardian signature**

\_\_\_\_\_  
**Date**



**Appendix D:  
Certificate of Medical Necessity for Medical Services**

**This information must be completed in its entirety by the patient’s healthcare provider.**

**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/Medical Services to be provided:** \_\_\_\_\_

**Dates Healthcare/Medical Services are to be provided:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**Contact Person at Office:** \_\_\_\_\_

**Contact’s Phone Number:** \_\_\_\_\_

**Contact’s Email Address:** \_\_\_\_\_

**Physician’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **NPI #:** \_\_\_\_\_

## Appendix D: Page 2

### DISCLOSURE/SIGNATURE:

The undersigned declare that the information provided on this Medical Services Application is true, correct and complete to the best of our knowledge and is being provided to JoshProvides Epilepsy Assistance Foundation, Inc. for the purpose of receiving financial assistance consideration. We understand that JoshProvides will consider one request at a time for an applicant. All decisions by JoshProvides 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 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: \_\_\_\_\_