PATIENT ASSISTANCE

POLICY GUIDELINES AND APPLICATION

MEDICAL SERVICES AND TRANSPORTATION AND TRAVEL: 2025 - 2026

JoshProvides Epilepsy Assistance Foundation, Inc. is a Section 501(c)(3) public not for profit charity ("JoshProvides") that offers grants for financial assistance to individuals whose neurologist/epileptologist ("Physician") diagnosed them with epilepsy or another seizure disorder ("Patient/Applicant"). JoshProvides strives to relieve qualified and approved Patients/Applicants from financial stress by providing financial assistance, in whole or in part, for a Qualified Service/Item recommended by the Patient/Applicant's Physician and provided such financial assistance is not available through private medical insurance, a government program (such as Medicare, Medicaid, etc.) or another not for profit charity. The following are examples of a Qualified Service/Items:

- Medical services and transportation and travel to/from medical service providers
- Seizure alert and detection devices
- Seizure response dog

Qualifications:
In order to qualify for a Grant, the Patient/Applicant must:

- Currently be under the care of a licensed Physician (as defined above)
- Certify and demonstrate financial need
- Submit a completed and executed Application for Financial Assistance ("Application"), along with any required documentation and a **picture of the applicant**
- Be able to clearly explain the amount of financial assistance requested and purpose of the request for financial assistance

Funds Availability
Applications are approved and Grants awarded when JoshProvides determines the Patient/Applicant certified and demonstrated a financial need for assistance towards the cost of a Qualified Service/Item and JoshProvides has the funds available to help with the cost of the Qualified Service/Item. JoshProvides reserves the right to suspend approval of Applications based upon resources available. ***JoshProvides does not pay personal expenses such as utilities, car payments, rent, etc. If an Application is approved and a Grant awarded, JoshProvides will make payment directly to the creditor/vendor/medical provider. 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 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 Please allow at least 30 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.

If you are applying for a Medical Services and Transportation and Travel Grant, please contact JoshProvides at 1-800-706-2740 to check criteria, funding caps and availability.

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?					

By signing below, the undersigned Patient/Applicant confirms and agrees that all information provided in this Application is true, correct, and complete and acknowledges and agrees that JoshProvides Epilepsy Assistance Foundation, a Section 501(c)3 public charity ("JoshProvides") will be relying on his/her certification in evaluating whether it will approve or disapprove the Patient/Applicant's request for financial assistance from JoshProvides. By signing below, the undersigned Medical/Health Care Provider certifies that the requested Qualified Service/Item is necessary in order to monitor, control, or reduce seizures of the Patient/Applicant.

PATIENT/GUARDIAN:

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

Print Name: _____ Date: _____

MEDICAL/HEALTH CARE PROVIDER:

Signature: _____ Phone #: _____

Print Name: _____ Email: _____

Address: _____ NPI Provider #: _____

Date: _____

MEDICAL SERVICES FINANCIAL ASSISTANCE REQUESTED – ALL INFORMATION REQUIRED GRANTS LIMITED TO THREE MONTH ALLOCATION FROM DATE OF AWARD							
Amount of funding requested	$		Indicate purpose of requested funds				
Name of facility or physician providing product or service							
Contact Name			Contact Email Address				
Vendor Address		City		State		Zip	
Vendor Phone #			Date of medical procedure or appointment				

TRANSPORTATION AND TRAVEL FINANCIAL ASSISTANCE REQUESTED – ALL INFORMATION REQUIRED GRANTS MUST BE USED WITHIN THREE (3) MONTHS FROM DATE THE GRANT IS AWARDED			
Amount of funding requested	$	Date of medical procedure or appointment requiring transportation assistance	
Indicate purpose of requested funds			

Medical Services and Transportation and Travel Application is accepted once in a twelve-month period.

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
- An Appendix D, Certificate of Medical Necessity and Transportation and Travel, completed in its entirety and signed by Patient's Physician

JoshProvides 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 Patient/Applicant certifies that he/she does not have sufficient resources to pay for the Qualified Service/Item requested in this Application due to one of the following:

- Patient has special circumstances that require financial assistance not available from any other source.
- Patient does not have or has insufficient coverage for a 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 requested Qualified Service/Item.

Financial Information

Applicant must provide proof of need for financial assistance

1. Family Annual Adjusted Gross Income: (Income Tax form 1040 Line #11)

   Tax year ending 12/31/20_____: _____

   Number of family members living in your home: _____

2. Type of Health Care Insurance Plan you have for you/your family (Select one)

   _____ An Individual health insurance plan (not offered through an employer)
   _____ An Employer-sponsored health insurance plan (offered through a private insurance company). Indicate insurance company: _____
   _____ Medicare
   _____ Medicaid
   _____ No insurance at this time

3. Have you submitted a claim to your insurance company for assistance: Yes ___ No ___

   If yes, what was their response: _____

   _____

4. Our goal is to help those who are most in need. Please describe your financial challenges. (Minimum of 100 words)

5. How would you/your family be impacted by receiving this grant? Please be as specific as possible. (Minimum of 100 words)

Certification

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

The undersigned Patient/Applicant certifies and acknowledges to JoshProvides that: (a) the undersigned is acting on behalf of and is an advocate for the Patient; (b) no portion of the financial assistance will be used for administrative purposes; (c) the patient's request for financial assistance is for a Qualified Service/Item and the financial assistance obtained will be used for a Qualified Service/Item. The Patient/Applicant further certifies that:

- The Qualified Service/Item is necessary for the Patient to monitor, control or reduce seizures;
- JoshProvides does not warrant or endorse any Qualified Service/Item requested by the Patient/Applicant 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 an Application is approved and a Grant awarded, JoshProvides only provides financial assistance, in whole or in part, for a Qualified Service/Item. The Patient/Applicant assume the sole responsibility for 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 best interests of the Patient;
- The Patient/Applicant's request for financial assistance is for a Qualified Service/Item;
- The Patient/Applicant 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. Patient/Applicant assumes all risks and consequences from the use of the benefit received (or not) from the Qualified Service/Item and releases 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/medical provider.
- 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 Application and must indicate if the photo may or may not be used by JoshProvides in social media, on its website, in other testimonial material or publications as indicated on Page 2 of Appendix D. All additional documents attached to this Application are deemed incorporated herein by reference and made a part of this Application.

GENERAL RELEASE

I understand that my 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 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 Patient/Applicant relied solely on his/her 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.

By signing below the Patient/Applicant agrees to this General Release and certifies and acknowledges that the financial information submitted in this application is true, correct, and complete.

Name: _____ Date: _____

Signature: _____

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

Appendix D:
Certificate of Medical Necessity for Medical Services and Transportation and Travel

This information must be completed in its entirety by the Patient/Applicant's Physician.

The specific date of service is required and must be no later than three (3) months from the anticipated date of the Grant award requested in the Application.

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 #:** _____

TRANSPORTATION AND TRAVEL INFORMATION:

Purpose of Travel: _____

Start Date: _____ End Date: _____

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DISCLOSURE/SIGNATURE:

The undersigned Patient/Applicant declares that the information provided in this Application is true, correct, and complete to the best of his/her knowledge and is being provided to JoshProvides for the purpose of consideration of a Grant. I understand that JoshProvides will consider one request at a time for a Patient/Applicant. All decisions by JoshProvides are in its sole absolute discretion and shall be final. The undersigned Patient/Applicant acknowledges that the undersigned and/or Patient may be required to submit additional information; and/or documentation to JoshProvides and hereby authorizes JoshProvides to contact the Patient's medical providers for verification purposes.

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

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

Print Name: _____

Date: _____