PATIENT ASSISTANCE

POLICY GUIDELINES AND APPLICATION

SEIZURE RESPONSE DOG: 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 Seizure Response Dog 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: _____

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				

JoshProvides applications for a Seizure Response Dog will only be accepted once the Patient/Applicant has raised and paid the breeder/trainer 80% of the total cost; and the dog is scheduled to be delivered within three (3) months of Grant award.

Payment is made directly to the breeder/trainer who is required to submit current W-9 for payment and invoice with balance due.

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 B, Certificate of Medical Necessity for Seizure Response Dog, 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 4 of Appendix B. 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 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 trainer. It is very important that each Patient/Applicant conducts his/her own research and due diligence, finds a trainer that is trusted and has a strong history of producing well-trained seizure detection 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 and breeder, if not the trainer.

This section must be completed by the Patient/Applicant'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/Medical Provider's Office/Group Name: _____

Office Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

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

Printed Name: _____ **NPI #:** _____

This section must be completed by the Patient/Applicant's breeder and trainer:

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? _____

_____

Dog's breeder (if different than the trainer):

_____

Address: _____

Phone #: _____

Email Address: _____

Website: _____

Has the breeder bred dogs for training as seizure response/detection dogs?

_____

Name of dog and breed being purchased: _____

Itemize in detail the total cost of purchase of dog from breeder or trainer:

_____

_____

_____

Breeder's Signature: _____ **Date:** _____

Printed Name: _____

Who will be your dog's trainer: _____

Trainer's Signature: _____ **Date:** _____
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/detection dogs?

_____

Have you checked the trainer's references, Google 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 (you can also 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? _____

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/DETECTION DOG IS NO LONGER NEEDED FOR ANY REASON, YOU ACKNOWLEDGE YOU WILL TRY AND RETURN THE SEIZURE RESPONSE/DETECTION DOG TO THE TRAINER TO FIND ANOTHER FAMILY IN NEED OF A DOG.

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

Print Name: _____

Date: _____

Appendix B: Page 4

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: _____