



**PATIENT ASSISTANCE
POLICY GUIDELINES AND APPLICATION
MEDICAL SERVICES GRANT**

Epilepsy Awareness of America (“EAA”) is a Section 501(c)(3) public not for profit charity that offers grants for financial assistance to individuals whose neurologist/epileptologist (“Physician”) diagnosed them with epilepsy or another seizure disorder. EAA strives to provide assistance to relieve qualified and approved Patients/Applicants from financial stress by providing financial assistance that is not available through private medical insurance, a government program (such as Medicare, Medicaid, etc.) or another not for profit charity. Examples for financial help would be: (a) Medical services; (b) Seizure alert and detection devices; and (c) Seizure response dog.

Qualifications: In order to qualify for a Grant, the Patient/Applicant must; (a) Currently be under the care of a licensed Physician (as defined above); (b) Certify and demonstrate financial need; (c) Submit a completed and executed Application for Financial Assistance (“Application”), along with any required documentation and a picture of the applicant; and (d) 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 Epilepsy Awareness of America determines the Patient/Applicant certified and demonstrated a financial need for assistance towards the cost of a Qualified Service/Item and Epilepsy Awareness of America has the funds available to help with the cost of the Qualified Service/Item. Epilepsy Awareness of America reserves the right to suspend approval of Applications based upon resources available. ***If an Application is approved and a Grant awarded, Epilepsy Awareness of America will make payment directly to the creditor/vendor/medical provider.***

How to Apply Complete the attached application with all required signatures, (including any required additional documentation). Only fully completed and executed applications for financial assistance will be reviewed and considered. Epilepsy Awareness of America reserves the right to approve or deny an applicant’s request for financial assistance.



APPLICATION FOR FINANCIAL ASSISTANCE
Only fully completed applications will be reviewed and considered.

Applicant Name: _____

Address: _____

City: _____ State: _____ Zipcode _____

Phone number: _____ Applicant Date of Birth: _____

Email address: _____

If not 18, please provide information on the Parent/Legal Guardian as the Applicant:

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zipcode _____

Parent/Legal Guardian Date of Birth: _____

Phone number: _____

Email address: _____



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 Epilepsy Awareness of America, a Section 501(c)3 public charity will be relying on his/her certification in evaluating whether it will approve or disapprove the Patient/Applicant's request for financial assistance. 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.

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

Date: _____

Witnesses:

Signature: _____

Date: _____

Print Name: _____

Signature: _____

Date: _____

Print Name: _____

Signature of Notary Public

Print Name and Number



To be considered for a Grant from Epilepsy Awareness of America, you will need to submit the following:

1. This Application, completed in its entirety and signed by all required parties;
2. A picture of the applicant; and
3. Certificate of Medical Necessity, completed in its entirety and signed by Patient's Physician

Epilepsy Awareness of America strives to be fiscally responsible with the donated dollars received from those who support Epilepsy Awareness of America and its mission. Epilepsy Awareness of America considers financial assistance for those applicants who have 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:

1. Patient has special circumstances that require financial assistance not available from any other source.
2. 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.
3. Patient has insufficient income or a lack of income.
4. Patient has no other resources or means to pay for the requested Qualified Service/Item.

Please check the insurance coverage you have at this time:

Type of Health Care Insurance Plan you have for you/your family:

_____ An individual health insurance plan (not through an employer):

_____ An employer-sponsored health insurance plan (offered through a private insurance company). Please state the name of the insurance company:

_____ Medicare or Medicaid

_____ No insurance at this time



If you have insurance, have you submitted a claim to your insurance company for assistance:

_____ Yes _____ No

What was the response:

Certification

The undersigned certifies to Epilepsy Awareness of America that no portion of the funds will be used for other than medical surgeries and or assistance in medical costs for items.

The undersigned Patient/Applicant certifies and acknowledges to Epilepsy Awareness of America 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; Epilepsy Awareness of America does not warrant or endorse any Qualified Service/Item requested by the Patient/Applicant for the benefit of Patient; Epilepsy Awareness of America 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, Epilepsy Awareness of America 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; Epilepsy Awareness of America 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 Epilepsy Awareness of America and its board 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. Epilepsy Awareness of America 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 Epilepsy Awareness of America in social media, on its website, in other testimonial material or publications. 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 Epilepsy Awareness of America is voluntary and that these benefits are a on a mission 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 EPILEPSY

AWARENESS OF AMERICA FOR THE RECEIPT OF A QUALIFIED SERVICE/ITEM, the undersigned, jointly and severally, represent and acknowledge (a) they have voluntarily requested Epilepsy Awareness of America's 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) Epilepsy Awareness of America 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 EPILEPSY AWARENESS OF AMERICA; (c) on behalf of themselves, their personal representatives, heirs, successors and assigns, release and indemnify, defend, save, pay and hold harmless Epilepsy Awareness of America and its board of directors, sponsors, agents, 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 of applicant, or if a minor, parent/guardian signature

Witnesses: _____

Name:

Date: _____

Name: _____

Date: _____

Signature of Notary

Print Name and Number

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 Epilepsy Awareness of America for the purpose of consideration of a Grant. I understand that Epilepsy Awareness of America will consider one request at a time for a Patient/Applicant. All decisions by Epilepsy Awareness of America 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 Epilepsy Awareness of America and hereby authorizes Epilepsy Awareness of America to contact the Patient's medical providers for verification purposes.

(Check One) I agree _____ do not agree ___ to allow Epilepsy Awareness of America to use the Patient's first name, testimonial and picture in announcements and related publications.

Signature: _____

Date: _____

Print Name: _____



Certificate of Medical Necessity for Medical Services

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):

Healthcare/Medical Services to be provided: _____

Dates Healthcare/Medical Services are to be provided: _____

Office/Hospital Address: _____

Contact Person at Office: _____

Contact's Phone Number: _____

Contact's Email Address: _____

Physician's Signature: _____ Print Name:

_____ Date:
