



APPLICATION FOR PATIENT ASSISTANCE GRANT PROGRAM

Upon receipt of an application packet, all information will be reviewed and verified if necessary. Applications are reviewed on a first-come, first-served basis on **completed** application packets. For this reason, please make sure your application is complete prior to submitting it. Applicants of incomplete packets will be notified via email and applications will not be considered until completed.

The disbursement of funds from the DSF Patient Assistance Grant Program will consist of the Board of Directors reviewing completed applications and making a determination. All applicants will receive notification via email regarding approval or denial of their application. Denied applicant may re-apply but will need to provide additional documentation that the child or family's circumstances have failed or that other possible alternatives have failed.

Our Grant cycle begins on February 1st and runs until funds are depleted for that year. We request up to 45 days to review your application. Applicants may apply for up to \$1,500 in equipment per year, with a lifetime maximum of \$5,000. Please direct any questions on this program by phone at 203.880.9456 or via email to maryanne.m@dravetfoundation.org.

PARENT/GUARDIAN & PATIENT INFORMATION (please print)

Date of application: _____

Parent/Guardian Information

First name: _____ Last name: _____

Address: _____ City, State, Zip: _____

Phone number: Home () _____ Work () _____

Cell () _____ Email address: _____

Patient Information

First name: _____ Last name: _____

Date of birth: _____ Male Female

CHILD'S DIAGNOSIS: (Include primary and secondary, if applicable)

EQUIPMENT REQUESTED: (Provide exact name of equipment/service; name of manufacturer or provider; and the name and contact information for the vendor. If available, please attach brochure and/or photos)

ESTIMATED COST:

INDICATE ANY SPECIAL CIRCUMSTANCES YOU FEEL ARE PERTINENT TO THIS REQUEST: (You may attach additional paperwork if necessary)

Completed packet must include:

- ✓ Completed and signed application
- ✓ A letter of medical necessity from the child's physician and/or a letter from a health care professional explaining how the child would benefit from the equipment you have requested
- ✓ A letter of denial from the child's insurance provider, which states that the specific equipment you are requesting has been denied
- ✓ Proof of all income (including your most recent W2 form)

Optional items to include:

- ✓ Any additional documentation (such as brochures) on the equipment requested
- ✓ Any additional documentation or narratives pertaining to the child or the nature of the request

By awarding these grants, the DSF is making no recommendation to the appropriateness or safety of a particular piece of equipment or therapy in treating Dravet syndrome and associated epilepsies and conditions. The DSF and its Board of Directors is not responsible for the safety and use of awarded equipment or therapies. Applicants are strongly urged to consult with their medical professionals and therapists regarding equipment and therapies that would be most beneficial for their situation.

We will not divulge application information without written consent from the applicant or their legal guardian. We do ask that award recipients submit a photo showing the child using their equipment or therapy that we may use for the advertising purposes of this grant program. Children will only be identified by their first name and only with written consent of their guardian.

I have read and understand the information above. I also understand that applications that are not completed in full or missing necessary documentation will not be reviewed until completed.

Date: _____

Signature of parent or guardian: _____

Relationship to child: _____

Please return your completed application packet and required documents either via email to maryanne.m@dravetfoundation.org (please write "PAG Program" in the subject line)

or by mail to:

Dravet Syndrome Foundation
Patient Assistance Grant Program
11 Nancy Drive
Monroe, CT 06468