Patient Assistance Grant Application for Caregivers

Caregiver Name ______________________________ ______________________________
First Last

Are you a member of the DSF Family Network?
- Yes
- No
- Unsure

Have you previously applied to DSF's PAG program?
- Yes
- No
- Unsure

Street Address____

City ___________________________ **State**_____ **Zip /Postal Code**_____________ **Country** _________

Phone (______**)**_________**-**______________ **Email** ______________________________________

Patient Name ____ **Date** __________________________

Gender
- Male
- Female

Child's Diagnosis (include primary and secondary, if applicable)

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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. If you are requesting more than 3 items, please contact Karen prior to submission.

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Estimated Cost -Please research the cost of your item(s) before submitting your application. An estimated cost must be listed, or your application will be rejected.

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Confirmation Checkbox *(Required)*

I acknowledge that I have researched the equipment requested. I understand that once any items are approved and ordered, they cannot be returned or exchanged for a different item.

________**Initial Here**

Liability Waiver *(Required)*

I understand that by awarding these grants, DSF is making no recommendation to the appropriateness or safety of a particular piece of equipment or therapy in treating Dravet syndrome or associated comorbidities. DSF and its staff and board are 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.

________**Initial Here**

Please email your complete application packet to karen@dravetfoundation.org. If you prefer, you may mail a complete packet to The Dravet Syndrome Foundation PO Box 3026 Cherry Hill, NJ 08034

A complete application packet requires includes the following documentation:

- ✓ Completed application
- ✓ A recent letter from the child's physician or health care professional explaining the medical necessity of your request
- ✓ A letter of denial from the insurance provider stating that the requested equipment and/or service was denied (when possible)
- ✓ Proof of all income (including your most recent W2 form)
- ✓ Any other documentation pertaining to the nature of your request. All information is kept confidential.

Signature *(Required)* ____**Date**________________