DOOSE SYNDROME EPILEPSY ALLIANCE

Joining Forces to Create Change

Patient Assistance Grant Application

The mission of DSEA is to find a cure for Doose Syndrome a.k.a. Myoclonic Astatic Epilepsy affecting young children. Our goal is to create a better understanding of Doose Syndrome through the collaboration of health care professionals and families across the world.
We are dedicated to creating a global initiative that will be aimed at:

- Increasing awareness and advocacy
- Providing financial grants to families that that have been struck by Doose Syndrome
- Funding research
- Constructing an International database

GRANT GUIDELINES:
• Patients must have a Doose Syndrome (MAE) diagnosis
• Patients applicants must be 18 years of age at the time of submission of this application
• If the Patient is a minor, please list Parent/Guardian as Grant Applicant
• Patients/Parent(s)/Legal Guardian of Grant applicants must enclose copy of identification.
• Grant applicants may submit one request per twelve month period, maximum of two lifetime awards.

INSTRUCTIONS: PLEASE READ THESE INSTRUCTIONS CAREFULLY.
Please use black ink, print clearly and complete ALL sections of the application. Incomplete applications will not be processed until missing information is provided.
Patient's Parent/Guardian (subsequently referred to as Parent(s)') Form Completion Check List:

- ✓ **I have signed and dated this application and have enclosed a form of identification (i.e. copy of driver's license).**
- ✓ **I have included copies of bills for which assistance is being requested.**
- ✓ **I have provided a current copy of income verification and other financial documents, requested within the application.**
- ✓ **I have completed each section accurately and legibly. Leave no section unmarked. If an item does not pertain to you, please mark with "N/A".**
- ✓ **I have included the Grant Request Verification form (page 2 of the application) completed by a referring professional, i.e. medical doctor (MD), registered nurse (RN), Forms will not be processed or reviewed without a referral.**

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 receive a letter listing why the application is incomplete. Applicants will not be considered until all forms are completed and the necessary documentation is submitted. The disbursement of funds from the DSEA Patient Assistance Grant Program will consist of the Board of Directors reviewing completed applications and making a determination. All applicants

will receive a letter of notification 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 January 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 $2,500US in funds per year, with a lifetime maximum of $5,000US.

Patient Name:_____Date:_____

Patient Date of Birth: _____

Patient Address:
_____

_____
_

What is the patient's health insurance coverage? _____
_____

Date of Diagnosis:_____

Current Diagnosis:_____
_____

_____
_____

_____
_____

What is the current treatment plan and duration? _____
_____

_____
_____

_____
_____

Name of Physician(s) treating patient: _____
_____

Has the patient had surgery for MAE? If so, what type and when?_____
_____

_____
_____

_____
_____

What are the parent's financial needs? ☐ Medication ☐ Medical related transportation Expenses ☐ Durable medical equipment ☐ Mobile Devices ☐ Dietary supplies ☐ Other

Please list "other" under comments, as well as a description of the item(s) needed.

Comments:_____

_____

_____

_____

Applicant's' Personal Information Profile

Please answer each question completely. Do not leave any blanks (use N/A as applicable). Be sure to sign application where appropriate. Please print and use black ink only.

Applicant personal information:

Patient's Last Name:_____First Name:_____Middle Initial _____

Applicant's Name:_____

Relationship to Patient: _____

Address:_____

City, State, Zip: _____

Telephone: Parent/Guardian (Home/Work/Cell)

_____

Where and when can you be reached most easily during the day?_____

_____

Applicant's email address: _____

_____

Who lives in the household?_____

_____

What are their ages?_____

_____

What financial support do you receive from extended family, friends, or other supports, i.e., church, businesses, social club?:_____

_____

_____
_____

Applicant's Monthly Income Financial Profile

Current Employment Status: (please check) ☐ Disabled ☐ Retired ☐ Unemployed

☐ Self-employed ☐ Employed Full time ☐ Employed Part time ☐ Full time student

☐ Part time student ☐ Homemaker

If you are employed, who is/was your employer? _____
_____

How long have you worked for this employer?_____
_____

What kind of work do/did you do?_____
_____

If unemployed, the date your job ended? _____
_____

If employment status has changed due to your child's disability/disorder, please provide date of change and previous monthly net take home pay. Date _____

Previous monthly net take home pay. _____

What kind of work does your spouse or partner do?_____
_____

What is the name of that person's employer?_____
_____

Please tell us about your current total. (MUST include ALL household income regardless of relationship to patient. If all income is NOT disclosed, application will NOT be processed.)

Household income; please complete each question entering not applicable (N/A) where appropriate.

INCOME SOURCES	**AMOUNT**	**Starting Date** (date you starting receiving this income)	**Ending date** (date you no longer receive this income)
1. Your monthly take home pay			
2. Your spouse/partner's take home pay			
3. Other household member's monthly take home pay.			

4. Monthly disability payments: a. Sick leave pay b. Employer group disability insurance c. Worker's comp d. Any personal disability insurance e. VA benefits f. Social security disability			
5. Public assistance			
6. Other Income: please list			

*Comments:*_____
_____

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_____

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Do you have Medical Debt as a result of the patient's epilepsy diagnosis? If yes, please provide amount and explain: (feel free to provide additional information on the back or a separate sheet.)

_____
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Do you have any incurring debt, not already covered above that you would like to disclose? If yes, please provide documentation, amount(s) and explain: _____
_____

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_____
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PLEASE ATTACH COPIES OF CURRENT BILLS FOR WHICH ASSISTANCE IS BEING REQUESTED (MUSTBE NO

Please provide the following information regarding the assistance you are requesting:
To be paid to:

Name on Account:
Account #

Other information:

Have you ever applied to Doose Syndrome Epilepsy Alliance before? ☐ Yes ☐ No
If yes, please give date and amount of grant:

If there is any other information about your situation that you want DSEA to consider, please note below or attach a se

I certify that the information provided on this application is true and accurate to the best of my knowledge. I h
services as a result of this application. I understand that the information is to be used to ascertain my qualific
Applicant and/or Patient. I give permission to DSEA and all affiliated entities to share the information as nece
and to obtain credit reports.

Please submit the completed application to:

Doose Syndrome Epilepsy Alliance
P.O. Box 15224
Colorado Springs, CO 80935-5224
Toll free phone and fax:1-855-Doose-Now (1-855-336-7366)

****Please be reminded that this application will not be reviewed unless it is completed in full****

Applicant's Signature:	Date:
Co-Applicant's Signature:	Date:

- ✓ **I have completed the Grant Request Verification form and affixed with my signature, my credentials, name of office or facility and address, and dated.**
- ✓ **Both pages 8 and 9 must be filled out and returned by the referring professional to info@doosesyndrome.org (or) DSEA, POBOX 15224, Colorado Springs, CO 80935-5224 (or) Toll Free fax 855-Doose-NOW (1-855-336-7366)**

✓ Name and Credentials of Referring Person: (Must be MD or RN)
Please print legibly:

_____

✓ Email:_____

✓ Address:_____

✓ City/State/Zip_____

✓ Phone:_____

Briefly outline patient's symptoms, severity, impact, duration:

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If relevant, outline current medication, patient risk assessment including therapies:

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- ✓ Signature of Referring Professional:_____
- ✓ Date:_____