Epilepsy Foundation of Nevada

2018/2019 Medical & Therapy Equipment Fund

About the Program

- Through the Medical & Therapy Equipment Fund we hope to alleviate some of the financial challenges faced by families of children diagnosed with epilepsy.
- Types of items considered for this program include (but are not limited to) : safety, seating, mobility, helmets, transport, comfort, positioning, bathing, feeding, etc.
- $500 per grant maximum.
- Requires certification of medical condition to be completed by child's primary treating physician.
- Funds can be awarded as either reimbursement for purchase, paid directly to the vendor, or in some cases reimbursement of insurance copay (additional information will be needed).

Eligibility and Program Details

- Grant applications will be reviewed by the Epilepsy Foundation of Nevada Advisory Board 4 times per year and grants will be awarded at these meetings. See the application deadline below. Applicates will be notified via email if they have been selected.
- Because of limited funding for this program the Epilepsy Foundation of Nevada can not guarantee all applicates will be awarded the grant. Applicates who did not receive a grant may reapply at a later time to have their application reconsidered.
- Eligibility

  Child must be under the age of 18 at time of application.

  Child must have a primary or secondary diagnosis of epilepsy.

  Child must live in the state of Nevada more than 50% of the time.

  Child/family must have been denied coverage by insurance company for equipment before applying.

Application Deadline	**Recipients Announced**
October 1, 2018	November 30, 2018
January 1, 2019	February 28, 2019
April 1, 2019	May 30, 2019

EPILEPSY FOUNDATION Nevada

Epilepsy Foundation of Nevada Fund Registration Form

Return form by mail or email to: Dmarano@efa.org

Address: EFNV, 2880 Bicentennial Pkwy Ste. 100-105 Henderson, NV 89044

Eligible Child Information

Name: _____ **Birthdate:** ____ / _____ / _____

Address: _____

Primary Diagnosis: _____

Date of Diagnosis: _____

Parent/Legal Guardian Information

Name: _____ **Email:** _____

Address: _____

Phone: _____ **Do you live with the child 50% or more of the time?** YES / NO

Do you live in the state of Nevada more then 50% of the time? YES/NO

Insurance Information

Does your child have health insurance? YES / NO **Insurance company name:** _____

Have you contacted the insurance company to request the item? YES/ NO (we require a denial from the insurance)

Contact date: _____ **Is there a copay for the equipment?** YES/NO **How much?** _____

Denial date:_____ **If denied please provide reason:** _____

Disclosure/Signature

[____] (initials) I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge.

[____] (initials) I understand that I may be required to provide evidence of submitted information and that the Epilepsy Foundation of Nevada may contact the medical facility for verification purposes.

[____] (initials) I agree to allow the Epilepsy Foundation of Nevada to use my name in announcements and related publications.

[____] (initials) I understand that I will be notified by email as to the status of this application and have provided a valid email address.

[____] (initials) I understand that the Epilepsy Foundation of Nevada, a 501(c)(3) nonprofit charitable organization, will consider this grant request and, in turn, may or may not grant this request.

Parent/Guardian Signature: _____ Date: ____ / _____ / _____

Parent/Guardian Print: _____

Epilepsy Foundation of Nevada Fund Request Form

Eligible Child Information

Name: _____ **Birthdate:** ____ / _____ / _____

Grant Request Information

Grant Amount Requested: _____ (Equipment request must be $500 or less)

1. Describe the child's medical conditions and the hardship in detail.

2. Describe the item(s) for which you are seeking funding or reimbursement.
   Applications MUST provide exact item requested. Please include name and description of item with picture, purchase location, size/color, and price. Applications not providing exact brand and model number will not be considered. (Please attach website address or catalog pages to describe item).

3. Please describe, in detail, how this item is being used or will be used (how often, medically necessary or medically convenient, etc.).

Epilepsy of Nevada Foundation Fund Request Form

Eligible Child Information

Name: _____ **Birthdate:** ____ / _____ / _____

Fund Request Information

4. Please describe, in detail, what ways this will contribute to an increased quality of life for the child and family?

5. Yes [___] No [__] Do you agree to provide information and/or photos of the child and/or the family using the granted equipment or items to share on our website and other printed materials? This will be used to help encourage donors to support our foundation in order to help us fulfill future grants for other families.
6. Yes [___] No [__] Have you applied for this fund in the past? If yes, please list dates and if you were approved.

_____

Local Involvement

Please describe your involvement with the Epilepsy Foundation of Nevada. List events and programs you have attend in the past, resources and information received, etc.

[____] Annual Walk [____] Annual Conference [____] Monthly Support Group

[____] Kid Crew [____] Studio e [____] Holiday Events

[____] Other: _____

Physician's Certification of Medical Condition

This page to be completed by physician

Eligible Child Information

Name: _____ **Birthdate:** ____ / _____ / _____

Address: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Child's Medical Information

The Parent/Legal Guardian of the child listed above has applied for a medical and therapy equipment fund from the Epilepsy Foundation of Nevada. Types of items consider for this program include (but not limited to) : seating, mobility, helmets, transport, comfort, positioning, bathing, feeding, etc.

Please complete the following medical information.

Child's Primary Diagnosis: _____

Child's Secondary Diagnosis (if applicable) : _____

How will having access to the therapy equipment listed above help to improve the child's quality of life?

_____

_____

_____

_____

Physician's Information

Physician Name: _____ **Title:** _____

Provider I.D. # : _____ **Telephone:** _____

Address: _____

Signature: _____ **Date:** _____ / _____ / _____

Physician: Thank you for taking the time to complete this information. Please return the form back to the child's parent and/or legal guardian so that they may attach it to their child's grant application.

EPILEPSY FOUNDATION
Nevada