Our mission is to improve the lives of children and families who are affected by PCDH19 Clustering Epilepsy. The Alliance focuses on raising and directing funds to scientific research with the goal of finding better, more effective treatments and, ultimately, a cure; providing information and support to affected families; and assisting the efforts of the medical community, so that no family suffers without a diagnosis and the most appropriate medical treatment.

APPLICATION FOR PCDH19 ALLIANCE 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 applications will be reviewed by the PCDH19 Alliance Board of Directors to ensure completeness and accuracy, and they will also make a determination of awards in the case of multiple applications.

All applicants will receive notification via email regarding approval or denial of their application. Denied applicant may reapply but will need to provide additional documentation that the child or family's circumstances have changed or that other possible alternatives have failed.

Our Grant cycle begins at 12:01am PST, June 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 $1,000 in equipment per year, with a life-time maximum of $5,000. In some cases, the PCDH19 Alliance may grant less than the full amount requested, depending on availability of funds . Please direct any questions on this program by phone at 925-209-6307 or via email to: julie@pcdh19info.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: _____

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)

Would you be willing to share photos of your child benefitting from this grant?	☐ **Yes**	☐ **No**
Would you be willing to share a quote about how this grant has improved your child's life?	☐ **Yes**	☐ **No**
Would you be willing to set up a First Giving page to help The PCDH19 Alliance raise funds?	☐ **Yes**	☐ **No**

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

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 PCDH19 Alliance is making no recommendation to the appropriateness or safety of a particular piece of equipment or therapy in treating PCDH19 Clustering Epilepsy. The PCDH19 Alliance 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.

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 via email to

Julie@pcdh19info.org (please write "PAG Program" in the subject line)