Hearts of Epilepsy Foundation
EPILEPSYID® PROGRAM

Emergency Assistance Grant
AUTHORIZATION FORM

(Please Print)

Last Name _____ First Name _____

Street _____ Apt. _____

City_____County_____State_____ Zip _____

Phone _____ Email _____

Date of Birth _____ Last 4 numbers of Social Security number _____

Emergency Contact _____Relationship _____ Phone_____

Physician's Name _____

Physician's Fax _____ Phone _____

When were you diagnosed with epilepsy? _____ Current Major Symptoms_____

_____

Is it OK for us to leave a detailed message about this application on your voice mail or with another household member, if you are not available? Yes No

Please include a written confirmation of diagnosis of epilepsy from your physician.

What service are you requesting assistance with? _____

_____

Explain briefly what circumstances has caused this situation. _____

_____

_____

Please attach any supporting documentation

Type of family/friend support _____

Do you have any children in the home? _____Ages _____

Are you employed? _____ Your Employer _____

Spouse employed? _____ Spouse's Employer _____

National Headquarters: 80 Monroe Avenue • Memphis, Tennessee 38103-2481
Office: (901) 453-6599 • Fax: (901) 572-1827 • info@heartsofepilepsy.org • www.heartsofepilepsy.org

MONTHLY GROSS INCOME (Less Withholding Taxes)	
Your Earnings	$
Spouse Earnings	$
Your Disability/Retirement Income Source	$
Spouse Disability/Retirement Income Source	$
Miscellaneous Income (Stocks, Bonds, Other)	$
Total Income	**$**
MONTHLY EXPENSES:	
Mortgage or Rent (Circle One)	$
Property Taxes and Insurance	$
Utilities	$
Food	$
Medical: Prescriptions	$
Doctors	$
Dentists	$
Insurance: Auto	$
Life	$
Health	$
Credit Cards	$
Time Payments	$
Car Payments	$
Auto Repairs	$
Gasoline	$
Miscellaneous Expenses:	$
Total Expenses	**$**
Disposable Income	**$**

The Foundation may require documentation of all or some of the above items.

I understand that assistance is granted under this program once per year. Participation is based on need and the availability of funds. I hereby release and hold the **Hearts of Epilepsy Foundation, Inc.** harmless from, against, and in respect of all claims, injuries, actions, demands, suits, losses, liability, or other damages that may be incurred as a result of accepting goods and services.

Applicant Signature: _____ **Date:** _____

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Please fill out this form and take it to your doctor to sign and date. We will need your doctor to confirm your epilepsy diagnosis. This form needs to be returned to the Hearts of Epilepsy Foundation, Inc.

Client's Name: _____

(Please print name & address)

Address: _____

Phone: _____

Email: _____

Doctor's Name: _____

(Please print name & address)

Phone: _____

Fax: _____

In order to process your program application, we are required to have a hard copy of your epilepsy diagnosis on file. Please have your doctor fax this confirmation form along ***with a copy of the doctor's letterhead or stamped with the doctor's office information and prescription*** stating that you have been diagnosed with epilepsy and are in need of the services that you are requesting.

Important: Doctor's Signature Required:

I can confirm that this patient has epilepsy.

_____

(Doctor's Signature) (Date)

All information obtained will be held in strict confidence and we will respect your privacy.

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To Whom it May Concern,

This letter authorizes: _____ (Company)

_____

_____

to release written and/or verbal information regarding my account to the ***Hearts of Epilepsy Foundation, Inc.*** for the purpose of providing financial assistance through their Emergency Assistance Grant.

_____ _____

Print Name Sign and Date

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Assistance with Medication Co-pay/Assistance

	Completed application
	Doctor's confirmation of epilepsy diagnosis on doctor's letterhead
	Copy of photo I.D.
	Document showing your monthly co-pay/assistance amount
	Proof of insurance
	Proof of income
	Reason/documentation as to financial need

First Name: _____

Last Name: _____ Zip code _____

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Quality of Life Survey

Please help us to provide the best services possible by answering a few brief questions about your need for services and its current impact on your quality of life.

Your responses will not affect – positively or negatively – the outcome of your application. The information contained in this survey is confidential and is not considered when evaluating your application for services.

This survey applies to your application for the **Emergency Assistance Grant,** though you may have applied for additional programs or services. When answering the following questions, please think about your application for the Emergency Assistance Grant.

Please consider this when answering the following questions.

	Not at All	A Little	Quite a bit	Very Much
How much does epilepsy affect your daily quality of life?	0	1	2	3
How much does the need your application addresses affect your daily quality of life?	0	1	2	3
How much do you think the requested service will improve your daily quality of life?	0	1	2	3
How confident do you feel about your ability to manage your epilepsy on a daily basis?	0	1	2	3

Please return in the enclosed envelope or email a scanned copy to: info@heartsofepilepsy.org

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