DREAMS FOR DANNY: Surgical Evaluation Scholarship Application

1. Your contact Information

Name

Address

Address 2

City/Town

State/Province

ZIP/Postal Code

Country

Email Address

Phone Number

2. Both parents/legal guardians of the child MUST agree to apply for this scholarship, even if the parents are separated or divorced. The only exceptions to this rule are if: 1) the other parent/legal guardian is deceased; 2) there is no other parent/legal guardian (e.g. single parent adoption); 3) only you have SOLE legal custody of the child. If you have SOLE legal custody of the child, you must upload a copy of the custody order.

The other parent/guardian must complete the short form application at the link below as proof of agreement:

What is your parental/guardian status?

- ◯ I am the mother and legal guardian
- ◯ I am the father and legal guardian
- ◯ I am the legal guardian, but not the mother or the father
- ◯ I am the parent with SOLE legal guardianship
- ◯ None of the above

3. If applicable, please upload a copy of the court order granting you sole legal custody of the child here.

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4. Child's date of birth

Date / Time

Date

MM/DD/YYYY

5. Is the child a U.S. citizen or permanent resident?

- Yes
- No

6. How many anti-seizure medications is your child taking at this time?

7. Is the child currently having infantile spasms?

- Yes
- No

8. What is causing your child's seizures?

9. Please tell us about your child's epilepsy journey:

10. What do you hope to gain from this surgical evaluation?

11. If your child has already had a prior surgical evaluation, please describe it here. Include the name of the hospital, names of the neurologist and neurosurgeon who evaluated your child, whether your child was deemed a candidate for any epilepsy surgery, and if so, which epilepsy surgery was recommended.

12. Please upload a letter from your child's neurologist or pediatrician which confirms that your child has been diagnosed with drug-resistant epilepsy. If you do not have a letter, you can upload a PDF or jpg (picture) of a hospital discharge summary, an email from your child's neurologist or pediatrician, or any other similar documentation.

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13. The maximum travel scholarship award is $1,000 per family. We ask that you request only what's absolutely necessary for your child to receive a surgical evaluation. Leftover funds will be used to provide another family with a travel scholarship if they meet the criteria.

What is the total amount you are requesting for this evaluation?

- [ ] $100
- [ ] $200
- [ ] $300
- [ ] $400
- [ ] $500
- [ ] $600
- [ ] $700
- [ ] $800
- [ ] $900
- [ ] $1,000

14. Please indicate the total amount needed for each allowable travel expenditure below:

Air, bus, or train fare ($)	
Gasoline ($)	
Lodging ($)	
Other transportation ($) (e.g. taxi, airport shuttle)	

15. Is your family experiencing financial hardship? If so, please describe:

16. Are you able to pay for travel costs up front, and then wait for reimbursement from The Brain Recovery Project after submission of receipts?

- ( ) Yes
- ( ) No, I am unable to financially pay for travel costs up front

17. Will you pursue a surgical evaluation if you are not awarded a travel scholarship under this program? Please explain:

18. I agree to provide The Brain Recovery Project with feedback after the surgical evaluation.

- Yes
- No

19. I agree that I will not contact peer review board members individually to advocate for approval of my application and understand that doing so will cause disqualification from consideration.

- Yes
- No

20. I agree to provide The Brain Recovery Project with all travel receipts and other expenditures under this program. I understand that failure to do so may result in denial of reimbursement.

- Yes
- No

Thank you for completing this application. Your application will be reviewed the first week of the next calendar month. You will be contacted after the 15th of the next calendar month to be advised of whether you have been selected to receive a travel scholarship under this program.

Remember, unless you have sole legal custody of the child, the other parent/guardian must complete the short form questionaire here.

We wish you and your family the best of luck.

Mail this application to:

The Brain Recovery Project
[redacted]69 Colorado Blvd. Suite 101
[redacted]os Angeles, CA 90041