Team Joseph & JB's Keys Family Assistance Program

Name of Duchenne patient for whom request is being made _____

Name of person filling out form _____

Relationship to Duchenne patient _____

Phone number _____ email _____

Treating physician _____

Please attach a confirmation of diagnosis – physician's letter, genetic testing results, etc.

Requested assistance (please provide as much detail as possible to help us make an informed decision and include both a description of the need and the cost)

Have you requested funding from any other organizations or funding sources? If yes, please describe and share the outcome of the request.

Have you attempted to have this expense covered by health insurance? If yes, please provide date of denial. If no, please explain.

Please tell us how this support will have an impact on your child's and your family's life.

Is there anything else you think we should know about your request?

Please fill out completely and return to Team Joseph by emailing form to andrea.miller@teamjoseph.org (send questions to Andrea at the same email). We'll let you know we received your application and we'll give you an answer to your request as soon as possible. Our goal is to review applications within a week of receipt. NOTE: If there are extenuating circumstances and you need us to review your application immediately, please make a note of that, above, in the response area for the question that asks if there is anything else we should know about your request.

"Never doubt that a thoughtful group of committed citizens can change the world. Indeed it is the only thing that every has." Margaret Mead