Multiple Sclerosis Foundation

ASSISTIVE TECHNOLOGY PROGRAM

QUALIFICATION APPLICATION

(Please Print)

Last Name _____ First Name_____

Street _____ Apt. _____

City _____ County_____ State _____ Zip _____

Date of Birth _____ Phone _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

Physician's Name _____

Physician's Fax _____ Phone _____

When were you diagnosed with MS? _____ 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 MS from your physician.

Do you or your spouse have Medical Insurance? ☐ Medicare ☐ Medicaid ☐ Private Carrier

Name of Private Insurance Company _____

What type of equipment do you have now? _____

_____

What additional equipment are you requesting?_____

_____

Type of family/friends support _____

Are you employed? _____ Your Employer _____

Spouse employed? _____ Spouse's Employer _____

National Headquarters: 6520 North Andrews Avenue, Fort Lauderdale, Florida 33309-2132
National Toll-Free Helpline: 888-673-6287 • Fax: 954-351-0630
support@msfocus.org • www.msfocus.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 documention of all or some of the above items.

I hereby release and hold the Multiple Sclerosis 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 or services.

Applicant Signature: _____ Date: _____

Multiple Sclerosis Foundation

Assistive Technology Program
DOCTOR'S CONFIRMATION FORM

Please fill out this form and take it to your doctor to sign and date. We will need your doctor to confirm your MS diagnosis. This form needs to be returned to the Multiple Sclerosis Foundation.

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 MS 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 presciption*** stating that have been diagnosed with MS and are in need of the services that you are requesting.

Important: Doctor's Signature Required:

I can confirm that this patient has multiple sclerosis.

_____
(Doctor's Signature) (Date)

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

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First Name: _____ Last Name: _____ Zip code _____

Multiple Sclerosis Foundation

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.

Please return in the enclosed envelope. If you prefer, you may complete this survey online at www.msfocus.org/survey1.aspx or email a scanned copy to survey@msfocus.org.

*This survey applies to your application for the **Assistive Technology Program,** though you may have applied for additional programs or services. When answering the following questions, please think about your application for the Assistive Technology program.*

Which reason best describes why you applied for this service **now?**

☐ A recent MS relaspse ☐ To maintain my health and wellness

☐ My MS worsening/progressing ☐ Other, please specify _____

"Quality of life" is your general sense of well-being, including health, comfort, safety, and self-
sufficiency. Please consider this when answering the following questions.

	Not at All	A Little	Quite a bit	Very Much
How much does MS 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 MS on a daily basis?	0	1	2	3

Thank you for completing this survey. A follow-up survey will be sent within six months.
For questions or concerns about this survey, call 800-225-6495 ext. 126.
Please return this survey in the enclosed envelope or mail to: Multiple Sclerosis Foundation, Attn: Survey Coordinator, 6520 N. Andrews Ave., Fort Lauderdale, FL 33309.