



Multiple Sclerosis Foundation

# EMERGENCY ASSISTANCE GRANT

## QUALIFICATION APPLICATION

*(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 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.**

What service are you requesting assistance with? \_\_\_\_\_

Explain briefly what circumstances has caused this situation. \_\_\_\_\_

***Please attach any supporting documentation***

Type of family/friends support \_\_\_\_\_

Do you have any children in the home? \_\_\_\_\_ Ages \_\_\_\_\_

Are you employed? \_\_\_\_\_ Your Employer \_\_\_\_\_

Spouse employed? \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

<b>MONTHLY GROSS INCOME (Less Withholding Taxes)</b>	
Your Earnings	\$
Spouse Earnings	\$
Your Disability/Retirement Income Source	\$
Spouse Disability/Retirement Income Source	\$
Miscellaneous Income (Stocks, Bonds, Other)	\$
<b>Total Income</b>	<b>\$</b>
<b>MONTHLY EXPENSES:</b>	
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:	\$
<b>Total Expenses</b>	<b>\$</b>
<b>Disposable Income</b>	<b>\$</b>

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

I understand that assistance is only granted under this program once. Participation is based on need and the availability of funds.

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: \_\_\_\_\_



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## Emergency Assistance Grant 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 prescription** 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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## Emergency Assistance Grant AUTHORIZATION FORM

To Whom it May Concern,

This letter authorizes: \_\_\_\_\_ (Company)

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign and Date

# Emergency Assistance Grant Checklist

## Assistance with Utility

Completed application
Doctor's confirmation of MS diagnosis on doctor's letterhead
Copy of photo I.D.
Copy of utility bill
Copy of past due/disconnect notice if available
Proof of income
Reason/documentation as to financial need



## Assistance with Rent

Completed application
Doctor's confirmation of MS diagnosis on doctor's letterhead
Copy of photo I.D.
Copy of entire lease
Copy of late notice/eviction notice
Proof of income
Reason/documentation as to financial need



## Assistance with Medication Co-pay

Completed application
Doctor's confirmation of MS diagnosis on doctor's letterhead
Copy of photo I.D.
Document showing your monthly co-pay 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.

**Please return in the enclosed envelope. If you prefer, you may complete this survey online at [www.msfocus.org/survey1.aspx](http://www.msfocus.org/survey1.aspx) or email a scanned copy to [survey@msfocus.org](mailto:survey@msfocus.org).**

*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.*

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

- A recent MS relapse                       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.**