National Multiple Sclerosis Society

Thank you for your interest in our Financial Assistance Program. Please note that all information provided is confidential and will not be released without prior consent. The following items are required in order to review your request for assistance:

- ☐ **Complete Application**
- ☐ **Documentation of the cost of the item/service for which you are seeking assistance. We *may* request multiple estimates for the item/service.**
- ☐ **Physician's prescription or other supporting documents if this is a medically-related item or service**
- ☐ **Confirmation of your diagnosis of MS** (if not previously provided). This could include a letter from your doctor, a copy of a medical record noting MS diagnosis, or a copy of a prescription for your MS disease-modifying therapy.
- ☐ **Names of 3 other agencies you have contacted with your request and the status of each (examples: United Way, places of worship, Multiple Sclerosis Foundation (MSF), medical insurance, etc.)**

Please return your completed forms to the address or fax number listed below:

National Multiple Sclerosis Society
Attn: Financial Assistance
Greater Northwest Chapter
192 Nickerson Street, Suite 100
Seattle, WA 98109

Fax Number: (206) 284-4972

All requests are reviewed on a case-by-case basis in accordance with Society-wide principles, standards and chapter policies. If community resources are available, we will help to connect & refer you to those first. We may also request additional information regarding your financial circumstances in order to fully understand your need. While we wish we could fund every person in need, please know that our funds are limited. Completing an application does not guarantee funding. We will process your application as quickly as possible. *Do **not** proceed with a purchase until you hear from us. Approved funds are paid directly to the vendor or service provider.* We will not reimburse for items already purchased. If you have any questions regarding the forms or our funding procedures, please call 1-800-FIGHT MS (1-800-344-4867).

For Office Use Only

Account No. _____

Date Received: _____

National Multiple Sclerosis Society

Application for Financial Assistance

I. Personal Information

Name _____ Date of Birth _____

Address_____

City/State/County/Zip _____

Telephone Primary #_____ Secondary #_____

Is it OK for us to leave a detailed message about this application on your voice-mail or with another household member? ____Yes ____No

E-mail Address _____

Current Neurologist/Primary Physician _____

Year of MS Diagnosis_____

II. Financial Information

Current Household Monthly Income: $_____

Total Number of Persons Living in Household _____

# of Adults _____ *# of Dependent Children* _____

Income Sources:

$_____ Employment (self)

$_____Supplemental Security Income (S.S.I.)

$_____Social Security Disability Insurance (S.S.D.I.)

$_____ Income (other household members)

$_____ VA Benefits

$_____ Private Disability Insurance

$_____ Other (e.g. pension, alimony, family support)

Total Cash, Checking, Savings, and Assets $_____

(Excludes retirement plan funds, IRA, 401K, home equity)

III. Medical Insurance

Please circle the appropriate response(s) Medicare Medicaid VA

Private Insurance No insurance

IV. Nature of Request

Financial assistance needed for (identify item/service)_____

Total cost of item/service, if known $_____

Amount *you* can contribute $_____

Amount secured *from other community/family resources* $_____

List (3) other resources you have contacted, amount received from each or status of your request (including: medical insurance for medical equipment & home health care requests):

1._____

2._____

3._____

Amount you are requesting from the National MS Society $_____

Explain *why* you require financial assistance at this time, explaining the circumstances surrounding your need for temporary assistance; please add additional pages as necessary:

_____

_____

_____

_____

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The National Multiple Sclerosis Society may have provided (or may provide) you with the names of products, vendors or services. Such information is provided to you solely for your consideration in accommodating your personal needs and the Society does not necessarily endorse these services or products. The National Multiple Sclerosis Society assumes no liability for provision of any service or use of any product.

The above information is complete and true to the best of my knowledge. By submitting this application, I give the National MS Society permission to obtain any further information relevant to this assistance request.

_____ _____

Signature of Applicant Date

Additional documentation or information may be requested to determine how to best address this request.

PLEASE SEND THIS FORM TO THE ADDRESS INDICATED IN THE COVER LETTER ALONG WITH THE DOCUMENTS LISTED IN THE COVER LETTER.