Account number (Office use only): _____

National Multiple Sclerosis Society
Community Service Provider Intake Form

Thank you for your interest in providing services to people living with MS. Please complete and return this form. The information provided, after being reviewed and approved, will be added to our referral database for information and referral purposes.

Individual Name:		
Company Name :		
Primary street address:		Additional Address Info:
City:	State:	Zip:
Phone number:		Fax number:
Company website:		Email: Is it OK to share your email address with patients? ☐ Yes ☐ No
What are your hours of operation?		
To what extent is your office accessible to persons with disabilities? (check all that apply) ☐ wheelchair accessible ☐ automatic doors ☐ entrance ramp ☐ accessible parking ☐ parking assistance (valet) ☐ office on ground floor ☐ elevator accessible (if above ground floor) ☐ accessible restroom		
Do you or other staff members speak a language other than English? ☐ No ☐ Yes If yes, please list languages:		
Please list any eligibility requirements for your services (e.g. referral requirements, age limits, income limits, counties, regions, etc.):		
Additional office location(s) with all contact information:		

Please answer any questions below that are applicable to your services. Please write "n/a", if necessary.

What services or programs do you provide that would benefit people with multiple sclerosis?
Do you have experience with people with MS or other physical disabilities and/or relevant training? If yes, please describe (e.g. MS or disability-related training or continuing education, number of people with MS served, etc.)
What is your area of specialty or your profession?
Please list any licenses, credentials, professional organization affiliations, or relevant specialized training:
Do you carry any form of professional liability (or comparable) insurance? ☐ No ☐ Yes If so, please describe: *(for National MS Society internal use only)*
What state/s are you licensed in?
Do you make home visits? ☐ Yes ☐ No
Please list all types of insurance accepted: ☐ Medicare ☐ Medicaid ☐ Dual Eligible (Medicare/Medicaid) ☐ Private Insurance ☐ Private Pay ☐ VA Benefits ☐ TRICARE ☐ Other (please describe):
Do you offer a sliding fee scale, indigent care or financial assistance? ☐ Yes ☐ No If yes, please describe:

Account number (Office use only): _____

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Please list anything else you would like us to know about yourself or your business:

By signing this intake form, I attest to the accuracy and validity of the information provided.
I give permission to the National Multiple Sclerosis Society to review this information and
to distribute the public information herein, for the sole purpose of providing referrals.

SIGNATURE:	DATE:
PRINTED NAME:	TITLE/POSITION:

Electronic Signature Agreement: By typing your name on this form, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature.

If National MS Society staff members have questions about any of the information provided in this form,
please list the name and phone number for the person to contact to get clarification
(if different than the name listed above):

PRINTED NAME:
PHONE NUMBER/EMAIL:

Please return completed forms by mail, email or fax to:

Connecticut Chapter
National MS Society
659 Tower Avenue
First Floor
Hartford, CT 06112
Phone: 860.913.2550
Fax: 860.761.2466
Website: www.ctfightsms.org
Email: programs@ctfightsms.org

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