National
Multiple Sclerosis
Society

Thank you for your interest in our Financial Assistance Program. Enclosed is our application form. 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:

- ☐ **Completed and signed Financial Assistance Application** (application enclosed)
- ☐ **Documentation of the cost of the item or service for which you are seeking assistance,** (e.g. an estimate or quote)
- ☐ **A written statement from your physician confirming diagnosis of MS** (if you have not provided this to us previously)
- ☐ **Physician's prescription or other documentation** (if this is a medically-related item or service)

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

National Multiple Sclerosis Society
Attn: Financial Assistance
Gateway Area Chapter
1867 Lackland Hill Parkway
Saint Louis, MO 63146

Fax Number: (314) 781-1440

All requests are reviewed on a case-by-case basis in accordance with Society-wide principles, standards and chapter policies. As we work with you on your request, we may also seek other funding options for you. If community resources are available, we will help you access those resources first. We may also request additional information regarding your financial circumstances in order to fully understand your need and how best to assist you.

While we wish we could fund every person in need, and will give your application thoughtful consideration, please know that funds are limited. Completing an application does not guarantee funding. We will process your application as quickly as possible and ask that you not proceed with a purchase until you hear from us. Approved funds are paid directly to the vendor or service provider. Typically, 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). We look forward to working with you and will be in touch with you soon.

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

Annual Household Income_____

Current Household Monthly Income: $_____

Total Number of Persons Living in Household _____

# of Adults _____ *# of Dependent Children* _____

Income Sources:

$_____ Employment (self) $_____SSI $ _____SSDI

$_____ Income (other household members)

$_____ VA Benefits $_____ Private Disability Insurance

$_____ Other (e.g. 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 None

Private Insurance (please specify name) _____

Other (please specify name) _____

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 these other resources and amount received from each:

_____

_____

Amount you are requesting from the National MS Society $_____

Please explain why you require financial assistance at this time. Provide as much detail as you can about your financial situation and other circumstances.

_____

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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.