National
Multiple Sclerosis
Society
Oregon Chapter

Oregon Chapter
National Multiple Sclerosis Society

5331 SW Macadam Avenue, Suite 290
Portland, OR 97239

Tel 800 344-4867
Fax 503 223-2912

info@defeatms.com
www.defeatms.com

Medical Equipment Program

The National Multiple Sclerosis Society, Oregon Chapter aims to empower people with MS to first utilize their own resources or community resources that may be available to them in acquiring medical equipment.

1. Have you checked with your private insurance, VA, Medicare, or Medicaid/Oregon Health Plan to see if they will pay for medical equipment?
2. Do you belong to any service organizations such as Rotary, or church groups that have equipment available?
3. Do you know of any resources or agencies in the community that may offer used or low-cost equipment? The Oregon Chapter can help you find these.
4. Have you tried to negotiate payment plans or reduced fees from vendors?

When these or other resources are unable to help you acquire equipment, and if the equipment is available in the Medical Equipment Program inventory, a person may apply to the program and be provided the equipment. The applicant must accept the equipment as is.

The Oregon Chapter will provide used and refurbished medical equipment to people with MS. The Chapter accepts donations of equipment and purchases new equipment occasionally. The Oregon Chapter can not guarantee that the Medical Equipment Program will be able to provide the type of equipment that an individual might need. Inventory of equipment for the Medical Equipment Program varies depending on equipment donations and chapter funding.

Should the equipment that the chapter gives you need repairs at some point in time, clients may apply to the chapter's Financial Assistance Program for help to pay for the repair of their equipment. Another option would be for clients to apply to the Oregon Chapter's Medical Equipment Program for replacement equipment.

If you need to access the Oregon Chapter's Medical Equipment Program, please complete the **Medical Equipment Application Form,** the **Program Agreement & Waiver of Responsibility Form**. Return them to the Oregon Chapter along with a statement of your MS diagnosis from your neurologist and a prescription from your doctor prescribing the medical equipment that you need.

If you have questions, please call the Oregon Chapter at 1-800-344-4867 and select option 1.

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Medical Equipment Program Application

Please attach your physician's statement of diagnosis and a prescription for the specific medical equipment.

Name:_____Date of Birth:_____

Address:_____

_____Phone:_____

Equipment Requested: _____Height:_____Weight:_____
(Height and weight is necessary. Equipment may vary depending on person's size.)

Physician's Name: _____Phone:_____

Insurance (check all that apply):
Medicare ___ Medicaid ___ Private___ Veterans___ Other___

Comments: _____

_____

_____

Please read and sign below.

The Oregon Chapter's Medical Equipment Program is designed to help people whose insurance is lacking and for whom purchase of equipment ***would be a financial hardship***. Because the Chapter does not require additional financial information, this signed request indicates hardship to us.

_____

Applicant/Guardian Signature **Date**

Typing name here constitutes valid signature.

FOR OFFICE USE ONLY

_____

_____

_____

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Program Agreement & Waiver of Responsibility

I understand that any and all durable medical equipment received from the National Multiple Sclerosis Society (NMSS) is offered "as-is" and without warranty or guarantee. I will also hold the National MS Society harmless from any claims of losses including damage, personal injury or death incurred because of defect or misuse of this equipment. I further agree that the equipment will be used as intended.

I also understand by signing this agreement and release, I and anyone entitled to act on my behalf, hereby waive and release the National Multiple Sclerosis Society and staff from all claims and liabilities related to providing me medical equipment through the Oregon Chapter's Medical Equipment Program.

I certify that I have read and understand the intent of this agreement.

Print Name: _____

Signature: _____

Date:_____

THIS AGREEMENT MUST BE COMPLETED for your application to be processed. Thank you.

Please return these application materials to:

Oregon Chapter, National MS Society
5331 SW Macadam Avenue, Suite 290
Portland, OR 97239