



**National Multiple Sclerosis Society**  
Ohio Buckeye Chapter

Thank you for your interest in our Financial Assistance Program. Enclosed is our financial assistance application form. We want you to know that all information you provide is confidential and will not be released to anyone without your written permission. We will need the following items from you to review your request for assistance:

- Completed and signed Financial Assistance Application Form (enclosed)
- Documentation of the cost of the item or service for which you are seeking assistance, e.g. an estimate
- A written statement from your physician that you have been diagnosed with 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)

Upon receipt, your request will be reviewed in accordance with our chapter policies. As we work with you on this request, we may also try to find other funding options for you. If other community resources are available, we will help you access those resources first. We may also ask for additional information about your financial circumstances so that we can fully understand your need and how we can best assist you. Our consideration is on a case-by-case basis, using Society-wide principles and standards. Approved funds will be paid directly to the vendor or service provider.

While we wish we could fund every person in need, and will give your application very careful consideration, please know that our funds are limited and completing your application does not guarantee that we will be able to meet your request. We will process your application as quickly as we can, and ask you not to proceed with a purchase until you hear from us. We will usually not reimburse you for items which have already been purchased.

Please return your completed forms in the enclosed return envelope. Please call 1-800-FIGHT MS (1-800-344-4867) if you have any questions regarding the forms or our funding procedures. We will be in touch with you soon and look forward to working with you.

Sincerely,

The Outreach Department

**JOIN THE MOVEMENT**

6155 Rockside Road Suite 202 Independence Ohio 44131 tel +1 800 667 7131 fax +1 216 696 2817 www.MSohiobuckeye.org



National  
Multiple Sclerosis  
Society  
Ohio Buckeye  
Chapter

## APPLICATION FOR FINANCIAL ASSISTANCE

### 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

Email: \_\_\_\_\_

Current Neurologist/Primary Physician \_\_\_\_\_

Year of Diagnosis \_\_\_\_\_

Total Number of Persons Living in Household \_\_\_\_\_

# of Adults \_\_\_\_\_ # of Dependent Children \_\_\_\_\_

Altair Record # (Chapter Use Only) \_\_\_\_\_

### Financial Information

Adjusted Gross Household Income: \_\_\_\_\_

*(This may be found on line #37 on Form 1040, line #4 on Form 1040EZ or line #21 on Form 1040A)*

Current Household Monthly Income: \$ \_\_\_\_\_ Number of people in household \_\_\_\_\_

Sources: \_\_\_ Employment (self) \_\_\_ Employment (other household members)  
 \_\_\_ SSI \_\_\_ SSDI \_\_\_ 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)*

### Medical Insurance Please circle the appropriate response(s)

Medicare      Medicaid      Private Insurance (please specify name \_\_\_\_\_)  
 VA              None

Other (please identify) \_\_\_\_\_

Please share with us why your *financial situation* necessitates your requesting assistance at this time. (Continue on other side if necessary)

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**Nature of Request**

Financial assistance needed for (identify item/service) \_\_\_\_\_

Total cost of item/service \$\_\_\_\_\_ Amount you can contribute \$\_\_\_\_\_

Amount secured from other community/family resources \$\_\_\_\_\_

List these other resources and amount received from each:

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Amount you are requesting from the National MS Society \$\_\_\_\_\_

Please describe circumstances surrounding your need for help with this particular item/service at this time (e.g. change in health status, family circumstances, safety concerns) and your plan to address these needs in the future (if applicable):

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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.*

**NOTES (Chapter use only):**