



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 or quote)
- 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.

*Please mail to:*

**National Multiple Sclerosis Society  
Attention: Financial Assistance  
Arizona Chapter  
5025 E. Washington Street, Suite 102  
Phoenix, Arizona 85035**

**Fax Number: (480) 966-4049**



# 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*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.



National Multiple Sclerosis Society  
Arizona Chapter  
5025 E. Washington St., Suite 102  
Phoenix, AZ 85034  
Tel 1 800 344 4867  
Fax 480 966 4049  
<http://aza.nationalmssociety.org>

## Consent for Release of Information

Applicant's Name \_\_\_\_\_

Address \_\_\_\_\_

*If Applicable:*

Company name \_\_\_\_\_

Account number \_\_\_\_\_

Total amount of bill \_\_\_\_\_

Amount being requested from NMSS \_\_\_\_\_

### **Purpose of the authorization**

- By signing this form, you authorize the disclosure and use of personal information submitted by you to the National Multiple Sclerosis Society, Arizona Chapter's Emergency Financial Assistance Program as part of your application packet.

### **Information we will disclose and/or use**

- I authorize the disclosure of information submitted by me as part of the application process pursuant to connection with community resources in meeting the needs of an identified emergent situation. Qualifying emergent situations will be mutually agreed upon between the applicant and the Chapter's Care Manager.

### **Expiration and revocation**

- A copy of this authorization is available to me upon request.
- This authorization shall be valid for two years from the date below. I have the right to revoke this authorization at any time. To revoke this authorization:
  - I must do so in writing and send my written revocation to NMSS, Arizona Chapter.
  - The revocation will not apply to information that has already been released in accordance with this authorization.
- The revocation will become effective upon receipt by the NMSS, Arizona Chapter.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_