Multiple Sclerosis Foundation

HEALTH AND WELLNESS GRANT

INDIVIDUAL PARTICIPATION PROGRAM & GUIDELINES

The Multiple Sclerosis Foundation offers direct support for anyone interested in health and wellness through a variety of educational materials, but, additionally, the Foundation provides special funding for health and wellness programs specifically for individuals diagnosed with MS.

These programs may include standard health and wellness therapies, such as adaptive yoga, aquatics and therapeutic horseback riding, or may include recreational therapies, such as art therapy or adaptive sports.

The goal of this national program is to enhance the safety, self-sufficiency, comfort, and well-being of those living with MS by providing services that can improve their quality of life. This program is specifically geared toward providing individual assistance only in special, isolated cases, or in remote areas where we do not currently have operating health and wellness programs.

Please Note: The Health and Wellness Individual Participation Grant is only offered once per year only.

Application Guidelines:

- Applicants are required to provide basic personal information, as well as a doctor's confirmation of both an MS diagnosis and the applicant's ability to participate in the program.
- Applicant cannot have any private insurance, government insurance (such as Medicaid), or benefits that would cover the cost of participation.
- Applicant must agree to sign a waiver of liability.
- Applicant must be a legal resident of the United States.
- Applicants are responsible for finding the Company/Service Provider where the classes/program will take place, as well as any and all schedules and costs. It is required that the classes are held in a structured and accessible setting, and that all instructors involved must be certified in the respective fields. Instructors should have a working knowledge of chronic conditions, particularly MS.
- All applications are considered on a case-by-case basis. And, because each class/program is unique, there is no predetermined dollar amount for each grant awarded.
- If the Foundation is unable to provide funding, we will strive to assist in locating other possible funding sources.
- If approved, funding will be paid directly to the Company/Service Provider. The Foundation may request a usage or attendance report from the Company/Service Provider.
- If you are unable to attend all sessions covered by the grant, or have missed any sessions, you should contact the Company/Service Provider to find out if you may be allowed to make up the missed time.
- In return for funding, the Foundation asks that you share a photo and story or testimonial to convey your experiences in the program.
- Applicant grants the Foundation the right to use his or her name and photograph for promotional purposes associated with this grant.

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Individual Participation Application & Release

(Please Print)

Last Name _____ First Name_____

Street _____ Apt. _____

City _____ County_____ State _____ Zip _____

Phone _____ Email _____ Date of Birth _____

Date of Diagnosis _____ Current Major Symptoms _____

Emergency Contact _____ Relationship _____ Phone _____

Do you or your spouse have medical insurance? ☐ Medicare ☐ Medicaid ☐ Private Carrier

Name of Private Carrier _____

Type of activity requested _____ Cost $_____

Schedule/day and time _____

Company/Service provider's name _____

Contact person's name_____

Phone _____ Email _____

Facility Address _____

Phone _____ Fax _____

The Participant named above understands and acknowledges that the Multiple Sclerosis Foundation is a charitable organization which does not have direct control or involvement in the delivery of the instruction or services provided, and cannot bear liability for any claims, damages, or injuries resulting from the Participant's attendance and/or acceptance of the services. Accordingly, the Participant hereby indemnifies, releases, and holds the Foundation harmless from, against, and in respect of all damages, including any claim, action, demand, loss, cost, expense, liability, penalty or other damage, including, without limitation, attorney's fees and other costs and expenses reasonably incurred in investigating or in attempting to avoid same or opposing the imposition thereof, or in enforcing this indemnity and release, resulting to the Participant from the treatment, care or other goods or services provided to the Participant by or through the Multiple Sclerosis Foundation.

_____

Applicant/Guardian

_____

Signature Date

National Headquarters: 6520 North Andrews Avenue, Fort Lauderdale, Florida 33309-2132
National Toll-Free Helpline: 888-673-6287 • Fax: 954-351-0630
support@msfocus.org • www.msfocus.org

MONTHLY GROSS INCOME (Less Withholding Taxes)	
Your Earnings	$
Spouse Earnings	$
Your Disability/Retirement Income Source	$
Spouse Disability/Retirement Income Source	$
Miscellaneous Income (Stocks, Bonds, Other)	$
Total Income	**$**
MONTHLY EXPENSES:	
Mortgage or Rent (Circle One)	$
Property Taxes and Insurance	$
Utilities	$
Food	$
Medical: Prescriptions	$
Doctors	$
Dentists	$
Insurance: Auto	$
Life	$
Health	$
Credit Cards	$
Car Payments	$
Gasoline	$
Miscellaneous Expenses:	$
Total Expenses	**$**
Disposable Income	**$**

The Foundation may require documention of all or some of the above items.

I hereby release and hold the Multiple Sclerosis Foundation, Inc. harmless from, against, and in respect of all claims, injuries, actions, demands, suits, losses, liability or other damages that may be incurred as a result of accepting goods or services.

Applicant Signature: _____ Date: _____

Multiple Sclerosis Foundation

Health and Wellness Grant
DOCTOR'S CONFIRMATION FORM

We will need your doctor to confirm your MS diagnosis, and to verify that you are able to participate in the program. Please fill out this form and take it to your doctor to sign and date. This form needs to be returned with your application, to the Multiple Sclerosis Foundation.

Applicant Name_____
(Please print)

Address:_____

Phone:_____ Email:_____

Type of Program:_____

Company/Service Provider's Name:_____
(Please print)

Doctor's Name:_____
(Please print)

Address:_____

Phone:_____ Fax: _____

In order to process your program application, we are required to have a hard copy of your MS diagnosis on file. Please have your doctor fax this confirmation form ***along with a copy of the doctor's letterhead or stamped with the doctor's office information and prescription*** stating that you have been diagnosed with MS and are in need of the services that you are requesting.

Important: Doctor's Signature Required:
I can confirm that this patient has multiple sclerosis and is able to participate in this program.

_____
(Doctor's Signature) (Date)

All information obtained will be held in strict confidence and we will respect your privacy.

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PLEASE BRIEFLY STATE THE REASON FOR YOUR NEED

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First Name: _____ Last Name: _____ Zip code _____

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Quality of Life Survey

Please help us to provide the best services possible by answering a few brief questions about your need for services and its current impact on your quality of life.

Your responses will not affect – positively or negatively – the outcome of your application. The information contained in this survey is confidential and is not considered when evaluating your application for services.

Please return in the enclosed envelope. If you prefer, you may complete this survey online at www.msfocus.org/survey1.aspx or email a scanned copy to survey@msfocus.org.

*This survey applies to your application for the **Health and Wellness Grant,** though you may have applied for additional programs or services. When answering the following questions, please think only about your application for the **Health and Wellness Grant.***

Which reason best describes why you applied for this service **now?**

☐ A recent MS relaspse ☐ To maintain my health and wellness

☐ My MS worsening/progressing ☐ Other, please specify _____

"Quality of life" is your general sense of well-being, including health, comfort, safety, and self-sufficiency. Please consider this when answering the following questions.

Please circle the best answer with regard to your MS using the following scale:

	Not at All	A Little	Quite a bit	Very Much
How much does MS affect your daily quality of life?	0	1	2	3
How much does the need your application addresses affect your daily quality of life?	0	1	2	3
How much do you think the requested service will improve your daily quality of life?	0	1	2	3
How confident do you feel about your ability to manage your MS on a daily basis?	0	1	2	3

Thank you for completing this survey. A follow-up survey will be sent within six months.
For questions or concerns about this survey, call 800-225-6495 ext. 126.
Please return this survey in the enclosed envelope or mail to: Multiple Sclerosis Foundation, Attn: Survey Coordinator, 6520 N. Andrews Ave., Fort Lauderdale, FL 33309.