Ontario & Nunavut Division
500-250 Dundas St. West
Toronto ON M5T 2Z5
Telephone: 1-800-268-7582
Fax: (416) 916-3124
www.mssociety.ca

Application For Funding Assistance

This is a fillable form, move the cursor to a blank field, click and type in your information. You can move to the next field by pressing the TAB key or moving the mouse to the next field and clicking it until you see the cursor. When completed, save and print a copy, sign where appropriate and fax, email or mail in the form with all accompanying doucmentation (HCP assessment, confirmation of diagnosis of MS and vendor/service provider quotes.

Form fields marked with an (*) are mandatory

A. Personal Information

	First*	Last*	Date*
Name*			

Address*		City*		Province*
Postal Code*		Phone (H)*		Phone(C) *
Email*				I do not have email

	Male	Female
Gender*		

	Primary Progressive	Secondary Progressive	Replasing Remitting	Clinically Isolated Syndrome
Type of MS				

Designated Contact Person if different from above

	First*	Last*
Name*		

Address*		City*		Province*
Postal Code*		Phone (H)*		Phone(C) *
Email*			I do not have email	

Source of Family Income

Client* Enter Y for all that applies:

Employed		CPP		CPPD		ODSP		LTD

Spouse/Partner* Enter Y for all that applies:

Employed		CPP		CPPD		ODSP		LTD

B. Health Care Professional Assessment and Signature

Please check off which request are being applied for:
Services and/or Incontinence/Catheter Supplies **Equipment and/or Air Conditioning**

A detailed written assessment by the appropriate health care professional must be attached in support of this application, including the following factors were applicable:

***Functional ability physical and cognative**
***Family and/or home support and benefit to client and family**
***Description of prescribed equipment, supplies and/or services needed**
***Comment on the clients motivation to use the equiupment**

HCP Name* Phone #*

Title* Agency*

HCP Signature* Date*

C. Services and Incontinence/Catheter Supply Requirements

Please check the service(s) and or supplies recommended for funding:*

Attendant Care Respite Care Transportation Emergency Response

House Cleaning Homemaking Child Care Yard/Snow Removal

Home Maintenance Driving Assessment Incontinence/Catheter(s)

Frequency of Service* Monthly Seasonally/Yearly

Total Cost of Services*
Amount of Funding Requested from MS Society

Please check off the services you currently have available from the following:

Attendant Care Community Care Access Centre Extended Health Benefits

Northern Health Travel Grant (Northern ON only) Other

Are you receiving the maximum number of hours from these services:

Yes No

D. Equipment and/or Air Conditioning Funding Requirements

Type of Equipment*

Size of Equipment*

Equipment has been trailed: Yes No Central Air: Yes No

Shared/Alternate Funding List Please Indicated the Amount Being Contributed**

Assistive Devices Program- ADP (ministry of Health) Amount*

Community Agencies (eg. Ontario March of Dimes or other) Amount*

Extended Health Care- Group Insurance Amount*

Ontario Disability Support Program- ODSP Amount*

Service Clubs (eg. Lions Club) Amount*

Person with MS/Family Contribution Amount*

Total Shared Funding*

Total Cost of Equipment*

Total Amount of Shared Funding* ( )

Total Amount of MS Funding Requested*

dors including delivery and/or installation if applicable.
le please consider getting quotes for used equipment.

en accessed, one quote is sufficient**

Privacy Policy

If you have any questions about your personal information, please contact our office at 1-800-268-7582
A copy of our privacy policy may be obtained by calling 1-800-268-7582 or at www.mssociety.ca.

E. Release of Information and Contact by MS Society of Canada

The Multiple Sclerosis Scociety of Canada, Ontario & Nunavut Division protects clients' privacy. The information collected is used to provide services to clients, information about programs and meeting, and to compile anonymous statistical information. It is shared with authorized individuals and companies outside the MS Society of Canada on a need to know basis, in relation to this application, only if a Release of Information Form is signed by the client. **By completing this form you hereby consent to the collection, use and disclosure of this information by the MS Society of Canada, as it relates to your application.**

(print name)

I ______________________ , hereby give my permission to release pertinent personal information including personal information from the Multiple Sclerosis Society of Canada, Ontario & Nunavut Division.

I wish to place the following restrictions on the release of information:

____

Dated at ______________ , the Province or Territory of ______________

this ______________ day of ______________ , 20 ______

Signature ______________ Address ______________

In addition, please indicate if representatives of the Multiple Sclerosis Society of Canada can identify themselves as a representative from the MS Society when contacting you and/or leaving information to initiate a return call.

(print name)

I ______________________ authorize and permit representatives of the Multiple Sclerosis to identify themselves as calling from the MS Society when returning my telephone calls or contacting me by telephone.

(signature or mark)

____

Membership Information:

If you are not a current member of the MS Society, would you like an MS Society representative to contact you about becoming a member? Yes ____ No ____

Contact Name: ______________ Phone Number: ______________

Please check if you would like staff to contact you to inform you of other programs and/or services. ____