Please ensure these are included:

- ❑ This Application completely filled out
- ❑ Doctor's Summary Note

Financial Assistance Grant

The information requested below is needed to complete the patient's application for financial assistance with copays, deductibles and other related expenses associated with treatment of a current Multiple Sclerosis diagnosis. The patient will be notified of the application determination. If you have any questions about this application or the application process, please contact MS Ability Alliance. at grants@msability.org.

Applicant Information:

First Name	Last Name		
Date of Birth	Phone Number	e-mail	
Address	City/Town	State	Zip
Contact Person *(if other than Applicant)*	Phone Number	e-mail	

Section 1 (to be completed by Healthcare Provider – REQUIRED)

Physician: (Regardless of specialty, who is responsible for ongoing patient care)

Provider Name	Title		
Specialty	e-mail / website		
Treating Facility Name			
Address	City/Town	State	Zip
Contact Person	Phone Number	e-mail	

Please return this completed form to:
grants@msability.org or mail to: MS Ability Alliance
426 Main Street Stoneham MA 02180

Section 2 (Required)

Diagnosis & Therapy

**Please attach a copy of your Doctor's Summary Note to this Application.*

Diagnosis:

State of the Disease:

Current Therapy:

Length of Treatment:

Health Care Providers Statement of Financial Assistance Necessity of Patient

I verify that the information in this portion of the application is complete and accurate. As the treating physician for the patient, I verify that I have prescribed the treatment regimen indicated above, based on my professional judgment of medical necessity. I understand that the patient must qualify financially and meet the program criteria to be eligible for assistance. I also understand that, if eligible, assistance may be limited by the terms and conditions as established by the Foundation and that the Foundation reserves the right at any time and for any reason, without notice to modify this application and modify or discontinue any assistance provided.

Healthcare Provider Signature Date

Please return this completed form to:
grants@msability.org or mail to: MS Ability Alliance
426 Main Street Stoneham MA 02180

Section 3 (Required)

Funds Requested:

Treatment	Frequency	Amount	Co-pay/ Deductible

Personal Statement:

Please provide a brief description of your needs and a little detail about yourself.

Please return this completed form to:
grants@msability.org or mail to: MS Ability Alliance
426 Main Street Stoneham MA 02180

Section 4 (Required)
Applicant Declaration:

I verify the information provided in my application is complete, accurate, and true. I further understand that our board as deemed necessary may verify the information provided. I understand that if I am approved for assistance by MS Ability Alliance, assistance will be terminated if the board becomes aware of any fraudulent activity related to my application or the assistance provided to me by the foundation. I understand that any assistance the foundation may provide is limited to the terms and conditions established by the foundation and that the foundation reserves the right at any time and for any reason, without notice, to discontinue assistance.

I authorize the foundation and its board or other representatives to obtain health information from my healthcare providers and other information necessary to complete the application process or verify the accuracy of any information provided with this application.

Patient Signature **Date**

Section 5 (Required)
Authorization to Release Medical Information

In order for me to receive assistance through MS Ability Alliance, I authorize my health care provider(s) and my insurance company(ies) to disclose to the foundation and its board and other representatives (collectively the foundation), information about me, my current medical condition and my health insurance coverage. The information can include spoken or written facts about me as well as copies of records from my health care provider(s) and my insurance company(ies) about my health or health care.

I understand that my health care provider(s) and insurance company(ies) will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however if I do not sign this authorization, I will not be eligible to receive assistance through the foundation. I may revoke this authorization at any time by mailing or emailing a signed letter of revocation to the foundation at the address listed below, but if I revoke this authorization, I will no longer be able to receive assistance through the

foundation. Additionally, I can tell my healthcare provider(s) and my insurance company(ies) in writing that I do not want them to share any more information with the foundation, but it will not change any actions the foundation, my health care provider(s) or my insurance company(ies) took before I revoke this authorization. I understand that the foundation will use and give out this information to see if I qualify for assistance and to run the foundation. In addition, the foundation may use and give out my information to refer me to, or to determine my eligibility for other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the cost of my drugs and treatments. I understand that the foundation will make every effort to keep my information private. This authorization expires the later of one year after the date it is signed or until I am no longer participating in the foundation program.

I verify that the applicant has authorized me to sign, on his/her behalf, the "Declaration" and the "Authorization to Release Medical Information" above/below, which I have read to the Applicant in full. By signing this, I am attesting to the fact that I have received such intentional and informed authorization from the applicant to sign the "Declaration" and the "Authorization to Release Medical Information" on his/her behalf.

I am entitled to a copy of this authorization.

Patient Signature **Date**

Waiver and Release of Liability

In consideration for being potentially considered to participate in programs, events, and or activities sponsored by MS Ability Alliance, I, for myself, my executor, administrators, heirs, and anyone entitled to act on my behalf, hereby waive discharges and covenant not to sue MS Ability Alliance, its management, officers, board members, members, sponsors, licensees, volunteers, their successors, and all for any and all liability, claims, demands, damages, causes of action, losses, or expenses arising out of my participation in the event and any related activities.

I understand that I may be photographed, filmed, or videotaped in connection with my involvement with MS Ability Alliance. I hereby irrevocably grant to MS Ability Alliance, its affiliates, licensees, and collaborators the absolute right and permission to distribute, publish, exhibit, digitize, broadcast, display, reproduce, photograph, videotape or otherwise use my name, picture, portrait, likeness, writings or biographical information (including if applicable, information regarding my disease diagnosis, prognosis and treatment), manner or media whatsoever anywhere in the world in perpetuity for any lawful purpose whatsoever, including without limitation, for editorial, educational,

promotional, and advertising purposes, for the solicitation of contributions, as evidence in litigation, and for any other purposes in furtherance of the purposes and objectives of MS Ability Alliance. I hereby release discharge and agree to save harmless MS Ability Alliance. and its employees or agents, affiliates, legal representatives or assigns, and all persons acting under its permission or upon its authority, from any liability by virtue of any publication of my likeness, including, without limitation, claims for libel or invasion of privacy. I further agree that MS Ability Alliance. shall be the exclusive owner of all copyright and other rights in such media. I have carefully read this Waiver and Release of Liability and fully understand its contents. I am at least 18 years of age and I am competent to contract in my own name. I am aware that this is a release of liability and a binding contract between myself and the persons and entities mentioned above and I sign it of my own free will. I understand that I am giving up substantial rights, including my right to sue.

I acknowledge that I am signing this Waiver and Release freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

First Name	Last Name
Primary Contact Phone Number	e-mail Address
Signature	Date

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