

TRANSPORTATION ASSISTANCE GRANT

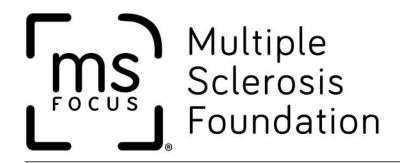
QUALIFICATION APPLICATION

(Please Print)

Last Name		First Name	
Street			Apt
City	County	State	Zip
Date of Birth	Phone	Email	
Emergency Contact			
Relationship		Phone	
Physician's Name			
Physician's Fax	Phone		_
When were you diagno	osed with MS?	Current Major Sym	nptoms
Monthly Gross Income \$	\$ Expenses \$ _	Total Rema	ining \$
•	re a detailed message abo d member, if you are no		•
Please include a writte	en confirmation of diagn	osis of MS from your p	hysician.
What type of transport	ation do you have now?		
•	paratransit fees, minor o appointment, infusion ce	-	-
What type of transport	ation assistance are you	requesting?	
☐ Paratransit fees	□ Minor vehicle repair	☐ Lyft ☐ Other, p	lease explain:
Describe any current fa	amily/friends support		
-			

Form continues on next page.

Con	nplete this section o	only if requesting	g transportation from Lyft.
Wha	t is your Lyft transportati	ify for this transportation, you must have access to a cell phone which eceive text messages. Ition is only available to and from a MS Center, neurologist's office or and get in and out of a vehicle independently? Yes No partner accompany you? Yes No No ease include a written confirmation of diagnosis of MS from your and hold the Multiple Sclerosis Foundation, Inc. harmless from, against, and in set, injuries, actions, demands, suits, losses, liability or other damages that may be a of accepting goods or services. Ure:	
□ Ne	eurologist appointment	\square Infusion Center	☐ MS Center
Lyft a	appointment location		
Date		Time	
out	-	_	_
• All	mobility aids must fit in	a standard car trunk.	
	order to qualify for this tra n send and receive text m	_	ast have access to a cell phone which
	s transportation is only a usion center.	vailable to and from	a MS Center, neurologist's office or
Can	you transfer and get in ar	nd out of a vehicle in	dependently? \square Yes $\ \square$ No
If no,	will a care partner accon	npany you? 🗌 Yes	□ No
Can	you send and receive text	! messages? □ Yes	□ No
	pplicants, please include ician.	a written confirmati	on of diagnosis of MS from your
respe	ect of all claims, injuries, action	ons, demands, suits, los	
Appl	icant Signature:		Date:
Mail	to: MS Focus, Attention: T 6520 North Andrews Fort Lauderdale, Florid	Avenue,	
or	Email: transportation@ Fax: 954-351-0630	amsfocus.org	



Multiple Sclerosis Diagnosis Request Form

In order to process your application, a confirmation of your MS diagnosis is required. The written confirmation must be provided on the doctor's letterhead, and be signed and dated by the doctor. Please return that information along with this form to the Multiple Sclerosis Foundation.

This information can be emailed, faxed, or mailed to us at:

Multiple Sclerosis Foundation 6520 North Andrews Avenue Fort Lauderdale, Florida 33309-2132

email to: support@msfocus.org

Fax to: 954-351-0630

Applicant's Name:		
	(Please print name)	(Date of birth)
	(Applicant signature)	(Date)
Doctor's Name:		
	(Please print name)	
Phone:	Fax:	
All information obtain	ed will be held in strict confidence	and we will respect your privacy



RELEASE

The Mu	_	andation, Inc. (MS Focus)	has offered to prov	vide transportation
				(Recipient)
Residir	ng at: Street			Apt
City		County	State	Zip
Transp	ortation for this pr	ogram may be provided b	y Lyft, or your loca	l paratransit
authori	ity.			
	Recipient understatis a charitable orgathe provision of the damages or injuring services. According Foundation harmly claim, action, denincluding, without reasonably incurrent the imposition the Recipient from the	accepts the above describe ands and acknowledges that the inization which does not have be goods or services and cannot be resulting from the Recipie gly, the Recipient hereby independent of the Recipient hereby independent, loss, cost, expense, liable the limitation, attorney's fees and in investigating or in attempted or in enforcing this indempted treatment, care or other good ough the Multiple Sclerosis Formatten and acknowledges that the acknowledges and acknowledges that the acknowledges and cannot be acknowledges and cannot be acknowledges and cannot be acknowledges and cannot be acknowledges.	ne Multiple Sclerosis I direct control or invo- not bear liability for a nt's acceptance of the emnifies, releases and ct of all damages, inco- pility, penalty or other and other costs and opting to avoid same of anity and release, resulted	Foundation lvement in any claims, e goods or d holds the luding any er damage, expenses r opposing lting to the
	Recipient			
	Date			

First Name:	Last Name:	Zip code
i ii st indirie.	Last Nattie	ZIP COUE



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 **Transportation Assistance Grant**, though you may have applied for additional programs or services. When answering the following questions, please only think about your application for the **Transportation Assistance 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
	ee of well-being, including health, comfort, safety, and self- en 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.