Multiple Sclerosis Foundation

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 diagnosed with MS? _____ Current Major Symptoms _____

_____

Monthly Gross Income $ _____ Expenses $ _____ Total Remaining $ _____

_____

Is it okay for us to leave a detailed message about this application on your voicemail or with another household member, if you are not available? ☐ Yes ☐ No

Please include a written confirmation of diagnosis of MS from your physician.

What type of transportation do you have now? _____

_____

This grant assists with paratransit fees, minor car repairs, and funds transportation to and from neurologist appointment, infusion centers or MS centers, allowing those with MS to seek treatment.

What type of transportation assistance are you requesting?

☐ Paratransit fees ☐ Minor vehicle repair ☐ Lyft ☐ Other, please explain:

_____

Describe any current family/friends support_____

_____

Form continues on next page.

Complete this section only if requesting transportation from Lyft.

What is your Lyft transportation assistance for?

☐ Neurologist appointment ☐ Infusion Center ☑ MS Center

Lyft appointment location _____

Date _____ **Time** _____

- In order to qualify for this transportation, you must be able to transfer and get in and out of a vehicle independently, or must be accompanied by a care partner who can assist you in transferring.
- All mobility aids must fit in a standard car trunk.
- In order to qualify for this transportation, you must have access to a cell phone which can send and receive text messages.
- This transportation is only available to and from a MS Center, neurologist's office or infusion center.

Can you transfer and get in and out of a vehicle independently? ☐ Yes ☐ No

If no, will a care partner accompany you? ☐ Yes ☐ No

Can you send and receive text messages? ☐ Yes ☐ No

All applicants, please include a written confirmation of diagnosis of MS from your physician.

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: _____

Mail to: MS Focus, Attention: Transportation
6520 North Andrews Avenue,
Fort Lauderdale, Florida 33309-2132

or Email: transportation@msfocus.org
Fax: 954-351-0630

Multiple Sclerosis Foundation

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
Fax to: 954-351-0630
email to: support@msfocus.org

Applicant's Name: _____ _____
(Please print name) (Date of birth)

_____ _____
(Applicant signature) (Date)

Doctor's Name: _____
(Please print name)

Phone: _____ Fax: _____

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

Multiple Sclerosis Foundation

RELEASE

The Multiple Sclerosis Foundation, Inc. (MS Focus) has offered to provide transportation costs for:

_____ (Recipient)

Residing at: Street _____ Apt. _____

City _____ County_____ State _____ Zip _____

Transportation for this program may be provided by Lyft, or your local paratransit authority.

The Recipient accepts the above described goods and/or services. The Recipient understands and acknowledges that the Multiple Sclerosis Foundation is a charitable organization which does not have direct control or involvement in the provision of the goods or services and cannot bear liability for any claims, damages or injuries resulting from the Recipient's acceptance of the goods or services. Accordingly, the Recipient 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 Recipient from the treatment, care or other goods or services provided to the Recipient by or through the Multiple Sclerosis Foundation .

Recipient _____

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

First Name: _____ Last Name: _____ Zip code _____

Multiple Sclerosis Foundation

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 _____

"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?				
How much does the need your application addresses affect your daily quality of life?				
How much do you think the requested service will improve your daily quality of life?				
How confident do you feel about your ability to manage your MS on a daily basis?				

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.