



Multiple Sclerosis Society of Canada

Société canadienne de la sclérose en plaques



Ontario & Nunavut Division

500-250 Dundas St. West
 Toronto ON M5T 2Z5
 Telephone: (416)922-6065
 Toll Free: 1-800-268-7582
 Fax: (416) 916-3124
 www.mssociety.ca

Application For The Quality of Life Grant Program

Once completed, sign where appropriate and fax, email or mail in the form with all accompanying documentation (HCP assessment, confirmation of diagnosis of MS and vendor provider quotes).

Form fields marked with an (*) are mandatory

A. Personal Information

Name*	First* <input type="text"/>	Last* <input type="text"/>	DOB <input type="text"/>
Address*	<input type="text"/>		City* <input type="text"/> Province* <input type="text"/>
Postal Code*	<input type="text"/>	Phone(H)* <input type="text"/>	Phone(C)* <input type="text"/>
Email*	<input type="text"/>		I do not have email <input type="checkbox"/>
Gender*	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>
Type of MS	Primary Progressive <input type="checkbox"/>	Secondary Progressive <input type="checkbox"/>	Relapsing Remitting <input type="checkbox"/> CIS or Allied Diseases <input type="checkbox"/>

Designated Contact Person if different from above

Name*	First* <input type="text"/>	Last* <input type="text"/>
Address*	<input type="text"/>	
Postal Code*	<input type="text"/>	Phone (H)* <input type="text"/> Phone(C)* <input type="text"/>
Email*	<input type="text"/>	
	I do not have email <input type="checkbox"/>	

Source of Family Income

Client* Enter "Y" for all that applies:

Employed <input type="checkbox"/>	CPP <input type="checkbox"/>	CPPD <input type="checkbox"/>	ODSP <input type="checkbox"/>	LTD <input type="checkbox"/>
OAS <input type="checkbox"/>	Other <input type="checkbox"/>			

Spouse/Partner* Enter "Y" for all that applies:

Employed <input type="checkbox"/>	CPP <input type="checkbox"/>	CPPD <input type="checkbox"/>	ODSP <input type="checkbox"/>	LTD <input type="checkbox"/>
OAS <input type="checkbox"/>	Other <input type="checkbox"/>			

B. Health Care Professional Assessment and Signature

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

*Functional ability, physical and cognitive

*Family and/or home support and benefit to individual and family

*Description of prescribed equipment needed

*Comment on the client's motivation to use the equipment

HCP Name*	<input type="text"/>	Phone #*	<input type="text"/>
Title*	<input type="text"/>	Email*	<input type="text"/>
HCP Signature*	<input type="text"/>	Date*	<input type="text"/>

C. Equipment and/or Air Conditioning Grant Requirements

Type of Equipment*	<input type="text"/>
Size of Equipment*	<input type="text"/>

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

		Applied Y/N
Assistive Devices Program- ADP (Ministry of Health)	Amount* <input type="text"/>	<input type="text"/>
Community Agencies (eg. Ontario March of Dimes or other)	Amount* <input type="text"/>	<input type="text"/>
Extended Health Care- Group Insurance	Amount* <input type="text"/>	<input type="text"/>
Ontario Disability Support Program- ODSP	Amount* <input type="text"/>	<input type="text"/>
Service Clubs, Foundations (i.e. Rotary, Labatt Better Together)	Amount* <input type="text"/>	<input type="text"/>
Person with MS/Family Contribution	Amount* <input type="text"/>	<input type="text"/>
	Total Shared Funding* <input type="text"/>	<input type="text"/>

Please fill in total cost of equipment, minus the shared funding and list amount needed:

Total Cost of Equipment*	<input type="text"/>
Total Amount of Shared Funding*	(<input type="text"/>)
Total Amount of MS Grant Requested*	<input type="text"/>

**Please submit two quotes from vendors including delivery and/or installation if applicable.
If recycled equipment is being considered please provide quotes for used equipment as well.**

****If ADP has been accessed, one quote is sufficient****

NOTE: All other sources of funding should be explored before an application will be considered for funding. After all sources of funding have been exhausted and if it is still a hardship for the individual/family to cover the remaining portion needed, an appeal can be made to the MS Society for additional funding.

D. Equipment Release for claims &/or damages

If the MS Society provides 50% or more towards the total cost of the equipment requested, the MS Society retains ownership and asks that when no longer required it be returned to the society if it meets the loans cupboard recycled program guidelines, for future use by others with MS.

The above-mentioned equipment is the property of the MS Society and is given on a permanent loan basis for as long as it is required. It is provided on the condition that the MS Society is not held responsible for any damages, claims or causes of action that might arise with respect to the equipment.

I release the Multiple Sclerosis Society of Canada from any claim that may arise from its use Initials:

The MS Society is not responsible for the maintenance and repairs. We do however recognize that this is an important component for you to maintain your independence. Therefore should you require funding assistance of repairs or maintenance, **please contact the MS Society prior** to having repairs or service done and your request will be considered.

We encourage you to maintain the equipment in a good state of repair for safety reasons. When the equipment is no longer required or further funding assistance may be needed for repairs or maintenance, please call the Ontario & Nunavut Division office at 1-800-268-7582 for more information and discussion of needs.

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

The Multiple Sclerosis Society of Canada protects your privacy. The information provided in this form and a brief summary of the service you requested will be entered into our services database. The information will be used to provide you with best services, to provide information about our programs and services and to compile anonymous statistical information. The information in this application form 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 this Release of Information Form is signed by the client. By completing this form you hereby consent to the collection, use and disclosure by the MS Society of Canada of your personal information for these purposes.

Consent

(print name)
I , hereby give my permission to the MS Society to retain and release my pertinent personal information in the delivery of these services.

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

Signature:

Date:

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 by phone &/or email when leaving information to initiate a return message.

Initials:

F. Declaration of Financial Need

I understand that the MS Society of Canada provides no-cost products ("Supports") to those affected by MS who would otherwise be unable, due to financial hardship, to afford those supports on their own.

I confirm that, without the assistance of the MS Society of Canada, I would not be able to obtain these supports based on my own financial means.

Initials:

Privacy Policy

If you have any questions about your personal information, or the MS Society's privacy policy and procedures please contact our Privacy Officer, at priv@mssociety.ca and phone 1-800-268-7582.

A copy of our privacy policy may be obtained by calling 1-800-268-7582 or at www.mssociety.ca

Membership Request (this is not a requirement for funding assistance)

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: