Multiple Sclerosis Society of Canada | Société canadienne de la sclérose en plaques

500-250 Dundas St. West
Toronto ON M5T 2Z5
Toll Free: 1-844-859-6789
Fax: (416) 916-3124
Email: equipment@mssociety.ca

Quality of Life Program - Equipment Application

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). **Fields marked with an (*) are mandatory.**

Important: Before starting or completing an application please review and carefully read the Quality of Life Equipment Program Guidelines found on MS Society of Canada website.

A. Personal Information

Name* First* Last* DOB*

Address* City* Province*

Postal Code* Phone*

Email* I do not have email

Pronouns* He, Him, His | She, Her, Hers | They, Them, Theirs | Ze, Hir, Hirs | Other

Type of MS Primary Progressive | Secondary Progressive | Relapsing Remitting | CIS | Allied Condition

Designated Contact Person If Different From Above

Name* First* Last*

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 | Provincial Income Support

OAS | LTD | Other

Spouse/Partner* Enter Y for all that applies:

Employed | CPP | CPPD | Provincial Income Support

OAS | LTD | Other

B. Health Care Professional Assessment and Signature

A detailed written assessment by the appropriate Health Care Professional (HCP) must be completed using the HCP Assessment Form (see section H). Please provide name and information of HCP completing this assessment.

HCP Name* | Phone #*

Title* | Email*

C. Equipment Funding Requirements

Type of Equipment*

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

	Amount	Applied Y/N
Government Device Programs		
Community Agencies		
Extended Health Care- Group Insurance		
Service Clubs/Foundations (e.g. Lions Club)		
Person with MS/Family Contribution		
Total Amount of Shared Funding*	$ 0.00	

Name all funding sources applied to:

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

Total Cost of Equipment*

Total Amount of Shared Funding* ($ 0.00)

Total Amount of MS Funding Requested (Max $1,000)*

Monthly household income after taxes*

Please indicate on the following table the number of household members currently residing at applicant address. *If the household income is above the stated LICO x 1.5 value for the number of people residing in household applicant is ineligble for funding (check only one)**

	Household	LICO x 1.5
	1 person	$2,684.00
	2 persons	$3,267.00
	3 persons	$4,069.00
	4 persons	$5,076.00
	5 persons	$5,780.00
	6 persons	$6,411.00
	7 or more	$7,041.00

Name of Company (vendor) that provided you with your quote for the equipment.*

Please provide the quote number or date of quote provide on the quote you received from the vendor.*

Address* City* Province*

Postal Code* Phone*

Email*

While the MS Society is not requiring me to submit a copy of the original quote I received from the vendor, I agree to retain and provide a copy if requested by the MS Society.* Initials

D. Quality of Life Impact

If your application is approved, how will this equipment improve your quality of life?

If the MS Society can only provide a portion of the funding that you are requesting, what impact would this have on your finances and/or quality of life?

E. Equipment Release for claims &/or damages

The above-mentioned equipment if funded by the MS Society is the of the property of applicant as long as it is required. The MS Society is not responsible for the maintenance and repairs. Funding 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

F. 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 anonymized 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 applicant. 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 and/or leaving information to initiate a return call.

Initials:

I also confirm that I have not already ordered and/or paid for the equipment for which I am requesting funding and that my quotes are valid.

Initials:

G: Declaration of Financial Need

I understand that the MS Society of Canada provides no-cost products ("Supports") to those affected by MS or an allied disease 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. I also understand that I may be required to provide additional information about my financial status.

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 or phone 1-800-268-7582.

H: Heath Care Professional (HCP) Assessment Form

Note: The health care professional (e.g., occupational therapist; physiotherapist; physician) who is prescribing the equipment, for which the applicant is requesting funding, must complete this form.

Form fields marked with an (*) are mandatory

Name* Phone #*

Title* Email*

Affiliated organization or business*

Patient's Name*

Describe the equipment that you are prescribing (e.g., ankle brace; walker; scooter).*

How will the equipment that you are prescribing specifically improve one or more of the applicant's MS or allied disease symptoms?*

Describe how this funding and equipment would support and benefit the individual and family.*

I can confirm the applicant has been diagnosed with MS or an allied disease?* Initials:

To the best of my knowledge, this assessment to be accurate and free of errors.

Signature Date:

Please return the completed HSP Assessment Form to the applicant for inclusion in their application.