

Applicant's Contact Information

Full Name	
Address	
City, State, and Zip Code	
Home Phone	
Cell Phone	
Date of Birth	

List other people living at this address	Age:	Relationship to you:	Employer:

What amount of financial assistance are you requesting? \$ _____

Briefly state how this financial assistance will be used if it is granted.

Have you requested financial assistance from any other agency regarding this need? _____

Health Information: Please have your physician fax a note confirming your diagnosis of M.S. to us at fax # 812-423-5650.

Date of M.S. diagnosis (year is fine):	
Current Neurologist's Name:	
Neurologist's Office Phone Number:	
Current Family Doctor/Primary Care:	
Family Doctor's Office Phone Number:	
Name of health insurance:	

Income Information

Employer (if applicable)	
How many hours per week do you work?	
What is your typical income?	\$ every

Benefits Information

Do you receive social security disability?	\$ per month
Do you receive SSI?	\$ per month
Are you eligible for VA benefits?	
Do you have a state medicaid/medical card?	
Do you draw a pension?	\$
Do you receive child support payments?	\$
Do you have any other source of income? List here.	

Medical Bills: List only those medical bills for the person with M.S. and only the bills that are M.S. related.

Medical Provider	Amount Owed

Expenses and Debts

Expenses and Debts Here	Amount per Month
Mortgage or Rent (circle one)	\$
Home Insurance	\$
Automobile Payment	\$
Auto Insurance	\$
Fuel Costs on Average	\$
Health Insurance premium	\$
Utilities on Average	\$
Medication Costs on Average	\$
Grocery Costs on Average	\$
Home Telephone	\$
Cell Phone	\$
Cable	\$
Internet	\$
Child Support you are required to pay	\$
Credit Card Debt	\$
	\$
	\$

By signing below, I certify that the facts contained in this application are true and complete to the best of my knowledge. I authorize verification of all statements contained herein and give permission for the Tri-State M.S. Association to contact parties listed on this application. I realize that failure to disclose requested information may result in denial of request for assistance.

Signature: _____ Date: _____

Submit application to the Tri-State M.S. Association at 909 A South Kenmore Drive, Evansville, IN, 47714 or fax to 812-423-5650. All applicants are required to have a physician fax a statement confirming the diagnosis of M.S. Please call us if you have any questions about this application. Our office number is 812-423-5943/1-866-514-4312.