MY MS FAMILY
100 O'Connor Crescent
Richmond Hill, Ontario, L4C 7N7
416.816.4787
www.mymsfamily.com

CLIENT SERVICES APPLICATION FOR FUNDING ASSISTANCE

Once completed, sign the application and submit by email to clientservices@mymsfamily.com, or by Canada Post to the address above, with required documents (quotes for equipment and service providers).

Personal Information

First Name: _____ Last Name: _____ Date: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Phone #: _____

Email: _____ Email for eTransfers (if different): _____

Gender: M_____ F _____ Other _____ Type of MS: _____

Designated Contact person (if different from above)

First Name: _____ Last Name: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Phone #: _____

Email: _____

Cost of on-going Services and / or Supplies requested

House Cleaning **($75/month max)** _____ Mobility Transportation **($75/month max)** _____

Incontinence/Catheters **($75/month max)** _____ Medical Alert Services **($75/month max)** _____

Other Supplies / Services (list all) _____

TOTAL COST OF SERVICES / SUPLIES (annualized): _____ (1)

Some services will be fully covered, others for a percentage, and always based on current funding available.

Shared/Alternative Funding List – on-going Services / Supplies (annualized)

Attendant Care March of Dimes $_____

Home Community Care Support (CCAC LHIN) $_____

Extended Health Care (Long Term Disability, Short Term Disability) $_____

Other incl. Family Support (list all) _____ $_____

Total Funding $_____ (2)

Amount Requested of MY MS FAMILY for services/supplies (annualized) (1)-(2) $_____ (3)

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Cost of one-time Equipment / Equipment repairs / Services requested (list all)

Type of Equipment _____

Estimate Cost of Equipment _____

Estimate Cost & Details of Equipment Repairs _____

Other Services (list all) _____

TOTAL COST OF EQUIPMENT / REPAIRS / SERVICES: _____ (4)

Please submit 2 quotes from vendors, including delivery and installation. If recycled equipment is available, please get a quote for that equipment. (IF ADP HAS BEEN FILED, ONLY ONE QUOTE IS NECESSARY)

Shared/Alternative Funding List - Equipment

Assistive Devices Program (ADP Ministry of Health) $_____

Community Agencies (March of Dimes, Lions Club, Rotary other) $_____

Extended Health Care (Group Insurance) $_____

Ontario Disability Support Program (ODSP) $_____

Other incl. Family Support (list all) _____ $_____

Total Funding $_____ (5)

Amount Requested of MY MS FAMILY for equipment (4)-(5) $_____ (6)

All other sources of funding should be considered before applying to MY MS FAMILY due to funding limitations. MY MS FAMILY will do its best to alleviate some of the financial burdens that applicants may be facing but if our funding has been exhausted, we will place the applicant on a waiting list in order of their date of application, and in some instances, in order of immediate need of the services.

MY MS FAMILY Funding request Grand Total

Annual - services/supplies $_____ (3)

One time - equipment / repairs / services $_____ (6)

Effective 2025-01-01 annual funding allowance for all services and equipment is $1,800 and subject to change. Application subject to review annually.

If and when application is approved, funds will only be released to client once receipts showing payment in full are received and reviewed by someone in client services.

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Release of Information and Contact by MY MS FAMILY

MY MS FAMILY will protect your privacy. The information provided in this form will be entered in our data base and a serial number will be given to each applicant. The serial number will be the only ID that will be visible on the data base. The information in this application form be shared with agencies who are part of the funding process if they request information. The applicant will be informed prior to the release of information. By completing this form, you hereby consent to the sharing of information by MY MS FAMILY with the respective agencies if and when the information is requested.

Consent

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

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

_____

_____

_____

On the _____ day of _____ in the year of 20 _____, in the province of _____

Signature: _____ or completed by _____

Address: _____

Privacy Policy: If you have any questions about this application form or any concerns, please contact us at clientservices@mymsfamily.com, 416-816-4787 or at www.mymsfamily.com.

This application has been reviewed by:

ADVISORY Board Member: _____ (Print name) DATE: _____

REQUESTING APPROVAL FOR: One Time: $_____

Annual: $_____

APPROVAL NOTES: _____

_____

_____

SIGNED: _____ DATE of APPROVAL: _____