APPLICATION FOR ASSISTANCE

PERSONAL INFORMATION

Name:____ SEX: Male Female
Last First

DOB:_____/____/______ SSN:______-______-_______

Address____
Street/PO Box (Apt) City, Sate Zip

Phone:____:_____:________ Email:____

MEDICAL HISTORY

Diagnosis:______________________________ Date of Diagnosis:_____________________

Current Physician:__________________________

Address:____ Phone:_____________

Treatment:_____________________________ How often:_______________________________

Symptoms:____

____

____

WORK STATUS

☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Student ☐ Unable To Work

Employer/Education Institute:____________________________________

Address:____ Phone:______________
Street City, State Zip

Supervisor's Name:____
First Last Title

How long have you been here?__________________ Position:_____________________________

Job Description:____

____

EXPENSES

List all expenses you currently have (ie Water 67.85 monthly)

Expenses	Cost	Frequency

INCOME

Gross Income:____________________ Net Income:_____________________

Cash gifts:_________________ Disability Income:_________________ How often:______________

Social Security Income:________________ How often:________________

FOR OFFICE USE

Income after expenses:_____________

ASSISTANCE NEEDS

☐ Financial (Paying a bill, Food, Housing Cost) ☐ Equipment (Cane, Walker, Wheelchair, Scooter)

☐ Home Improvement ☐ Medical (test, treatment, physical therapy, counseling) ☐ Resources

Describe what exactly you need: (Attach paper if more space is needed)

Needed by:____/_____/______

PLEASE COMPLETE THE SECTION FOR THE ASSISTANCE YOU ARE SEEKING

1. **FINANCIAL ASSISTANCE**

Who will be receiving the assistance: ☐ Medical Profession ☐ Business ☐ Private Practice ☐ Self

How much do you need?__________________ How much are you asking for?____________________

Name of Institution:___________________________________

Address:____ Phone:____________________
Street City, Sate Zip

How will this help you?____

____

____

How often do you need this? ____________________ Will you be able to cover cost in future? Yes No

Have you received assistance for this before? Yes No (if yes explain) ____________________________

____

Would you need constant financial assistance?_____________________

Instructions for Review:

1. Attach a copy of the bill with application
2. Contact information of Institution
3. Person to Contact

2. EQUIPMENT

What equipment is needed?______________________________________ How many:___________

Type:___________________________ Brand:______________________

Condition: New Used Estimated Cost:____________________________

Where are you trying to get this equipment from:____

Size:_________________________ Height:__________

Has a doctor or physical therapist told you this was needed? Yes No

Physician:____ Title:______________________
First Last

Address of Practice:____
Street City, State Zip

Phone:_______________________

3. HOME IMPROVEMENT

Estimated Cost:______________
Do you have a contractor you already work with? Yes No (if yes who)

Company:____ Phone:___________________________

Contractor:___________________________________
First Last

Supplies List (**OFFICE USE)**

4. MEDICAL

What medical assistance do you need: ☐ Test ☐ Treatment ☐ Physical Therapy ☐ Counseling
☐ Other (please describe)____

____

Cost of medical needs?___________________ Who is providing the service?_______________________

Address:____ Phone:________________________
Street City, State Zip

Person of Contact:____
First Last

5. RESOURCES

Please Visit our website for a list of resources. If you can't find what you're looking for or cannot access our site please call us.

MSterious Miracales www.msteriousmiracles.org | 720-854-8012
MS Society www.mssociety.org | 1-800-344-4867
Rocky Mountain MS Center www.mscenter.org | 303-788-4030
Food Assistance www.hungerfreecolorado.org | 855-855-4626 or 720-382-2920
Crisis Hotline www.coloradocrisisservices.org | Text "TALK" to 38255 | 1-844-493-8255

Please include the following items:

1. 2 references (Name, Phone, Relationship)
2. 3 months of bank statements
3. Disability letter (If Applicable)
4. Documents or letters from Doctor, Nurse, or Medical Profession stating you need the items your requesting to improve health and/or living situation (If Applicable)