



**Southwest Louisiana
Multiple Sclerosis Foundation
P. O. Box 51988
Lafayette, LA 70505-1988**

Application for Financial Assistance

Date _____ Date Diagnosed with MS _____

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Age _____ Last 4 digits of SSN _____

Employer _____ Emp. Phone _____

Occupation _____ Years Employed _____

Family Contact _____ Phone _____

Neurologist _____ Phone _____

Others Living at Home/Relationship

_____/_____ / _____/_____

_____/_____ / _____/_____

I need help because: _____

Items Requested	Where can items be purchased?	Cost
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Signature of Applicant _____



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Have you applied for assistance with your Insurance Company or other organizations?
 Y N If yes, explain: _____

Monthly Income Information:

Expenses:

Personal Salary \$ _____
 Spouse's Salary \$ _____
 Others Living at Home Salary \$ _____
 Retirement \$ _____
 Social Security Benefits \$ _____
 Welfare \$ _____
 SSDI/SSI \$ _____
 Food stamps \$ _____
 Other Income _____ \$ _____
 Other Income _____ \$ _____
TOTAL MONTHLY INCOME \$ _____

Home \$ _____
 Utilities \$ _____
 Insurance \$ _____
 Auto \$ _____
 Other \$ _____
TOTAL \$ _____

Please attach any additional documentation, prescriptions or other necessary information to this application.

This signature authorizes the Foundation to verify information to be accurate and true.
 Signature of Applicant _____

DO NOT WRITE IN THIS SECTION—FOR FOUNDATION USE ONLY

Recommendation : _____

Date: _____

Foundation Approval:

One Time Payment: _____

Monthly Payments: _____

Date of Payment(s): _____
