Section A

Please complete and return to: MS Society of Canada, London Middlesex Chapter
Regional/Chapter/Unit Address: 21 Grosvenor St. RM#W020, London ON N6A 4V2
Telephone Number: 519-646-6030 ext.1
Fax: 1-416-916-3124
Contact Person: Sanjay Moonsammy or Christine Williams
E-Mail sanjay.moonsammy@mssociety.ca or christine.williams@mssociety.ca

Section B

Applicant’s Personal Information

Name: ________________________________

Address: ________________________________

Tel: Home: (________) ______________________ Business: (________) ______________________

Date of Birth: __________________________ Email: __________________________

DD     MM     YY

Source of Family Income:

Applicant: Employed ☐ CPP ☐ CPPD ☐ Pension ☐ ODSP ☐ LTD ☐ Other Income __________

Spouse/Partner: Employed ☐ CPP ☐ CPPD ☐ Pension ☐ ODSP ☐ LTD ☐ Other Income __________

Privacy

If you have any questions about your personal information, please contact our privacy officer (Pauline Tardif, Vice President, Ontario Division at 1-800-268-7582 ext. 3037). A copy of our privacy policy may be obtained at any MS Society office by calling 1-800-268-7582 or at www.mssociety.ca.

Please note: The MS Society will retain ownership of equipment for which it has contributed 50% or more or provided from existing inventory.
Section C

Community Health Care Professional: (in consultation with Client/Applicant)
Please attach a copy of your assessment or indicate that ADP under the MOH will be accessed.*

Type of equipment:__________________________________________________________

The following information is required in your assessment.
- Physical status
- Present functional disability
- How the client/family will benefit from the use of the equipment
- Comments on the client’s motivation to use the equipment
- Has the client/family tried out the equipment requested?
- Description of prescribed equipment

Name:__________________________________ Telephone Number: (_____)

Title:______________________ Agency:_____________________________________

Signature (Health Care Professional) __________________________ Signature (Client/Applicant) __________________________

Date of Application: __________________________ DD MM YY

Section D

Shared/Alternate Funding Checklist:
This section is to be completed by the Client/Applicant and the Health Care Professional.
Please indicate the amount being contributed.
*Assistive Devices Program A.D.P. (Ministry of Health) Amount $________
Community Agencies (eg. Ontario March of Dimes) $________
Extended Health Care/ Group Insurance $________
Ontario Disability Support Program O.D.S.P. $________
Other (eg. Service Clubs) $________
Person with MS/Family Contribution $________

Total * $________

Cost of equipment $________
G.S.T. charged $________
Total Cost of equipment $________

Total amount of shared funding *($________)
Total amount of MS funding requested **$________

Please submit two quotes from vendors including delivery and/or installation if applicable.
** If ADP has been accessed, one quote is sufficient.
Section E

Release of Information and contact by MS Society of Canada

The Multiple Sclerosis Society of Canada, Ontario Division protects clients’ privacy. The information collected is used to provide services to clients, information about programs and meetings, and to compile anonymous statistical information. It 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 a Release of Information Form is signed by the client. By completing this form you hereby consent to the collection, use and disclosure of this information by the MS Society of Canada, as it relates to your application.

I, _____________________________, hereby give my permission to release pertinent personal information including personal medical information from the Multiple Sclerosis Society of Canada, Ontario Division.

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

______________________________________________________________________________________________

Dated at _______________________, in the province of ________________________________, (town/city)
this _______________________ day of ________________________________, 20______________

______________________________________________________________________________________________

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.

I, ________________________________, authorize and permit representatives of the Multiple Sclerosis Society of Canada (print name) to identify themselves as calling from the MS Society when returning my telephone calls or contacting me by telephone.

______________________________________________________________________________________________

Section F (Office use only) Region/Chapter/Unit area:__________________________________________

Funding Reviewed by:_________________________ Date: __________________

Funding Approved by:_________________________ Date: __________________ Amount Approved: $__________

Funding Refused by:_________________________ Date: __________________

Comments:________________________________________________________________________________