Financial Assistance Application

Applicant name _____ Date of Application _____/_____/_____

APPLICATION DETAILS

Please use the "MSU Financial Assistance Help Guide" (on our website at Understandingmyositis.org/docs/MSU-Financial-Assistance-Help-Guide.pdf) when applying for financial assistance. It contains detailed information about this application, what we require you to send to us based on the type(s) of assistance you are requesting, and additional forms required for medical travel assistance. All supporting documents, including signed forms, must be included to be considered for an award. Requests for assistance are evaluated on a case-by-case basis and are subject to funding availability as well as eligibility and financial need. Patients may be eligible to receive up to a maximum of $1,000 per rolling year from MSU. Financial Assistance is available for U.S. residents. **NOTE**: Applicants and potential recipients of financial assistance should discuss any ramifications with their caseworker, accountant, or lawyer.

Applications, supporting documents, and signed forms can be sent using the information below. Please do not send health records or diagnostic test reports, as we do not need this information.

Email: Office@UnderstandingMyositis.org

Mailing Address: MSU, 9125 N. Old State Road, Lincoln, DE 19960.

SECTION A: PERSONAL DEMOGRAPHICS, DIAGNOSIS, TREATING DOCTOR

Patient's Name (First, Middle, Last) _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone Number _____ Email Address _____

Type of Myositis _____ Diagnosing/Treating Doctor Name_____

If applying on behalf of another person, please provide the information below. See examples in help guide.

Non-Patient Applicant's Name, Phone Number/ Email Address, and Relationship:

_____

Reason for applying on their behalf: _____

SECTION B: HOUSEHOLD INCOME

Total Monthly Gross **household** income $_____

Household size, including yourself? _____ How many adults provide support to the household? _____

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SECTION C: SAVINGS ACCOUNTS

☐ Check here if household does NOT have any Savings Accounts

Please list savings accounts in the space provided below. Include any fundraising accounts that have been established on your behalf. Add additional on the back if needed. (See Help Guide for required documents)

Bank Name	**Average Daily Balance**	**Account Number (last 4 digits)**
_____	_____	_____
_____	_____	_____

SECTION D: TYPE OF FINANCIAL ASSISTANCE REQUESTING

This section applies to the type(s) of financial assistance you are requesting. Please only answer those related to the type(s) you are applying for. (See Help Guide for important details) Combined total not to exceed $1,000.00.

Type(s) of Expenses and amounts for which assistance is requested (Please check all that apply):

☐ Medical Bills: Amount Requested: $_____

If you have health insurance, have they paid their part? YES or NO

☐ Household: Type of expense(s)? _____

Amount Requested: $_____

☐ Medical Travel to see Myositis Specialist

See the Help Guide for important, required information, and additional required forms.

Scheduled Appointment Date(s): _____

Name, Full Address, and Phone Number of the doctor/hospital you are traveling to:

_____

# of hotel nights: _____ *(If any. See Help Guide)*

Driving / Bus / Train / Flying *(Circle one)*

Caregiver traveling with you? Y / N *(Circle one)*

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ADDITIONAL INFORMATION

You may attach a personal statement to your application if you think there is any information not included here that would help us to make a determination.

For medical travel assistance, a detailed letter outlining your travel needs is highly recommended, including addresses, dates of travel, and any other pertinent details.

Based on the type of assistance and individual situations we may request additional information and documentation before we are able to process your application.

To expedite the processing of your application, we will attempt to notify you via email, if listed, should we have questions or require additional documents. A mailed copy of the request will also be sent to the address you list on this application.

Add Office@UnderstandingMyositis.org to your contacts and check your spam/junk folders for any emails.

APPLICATION CHECKLIST

The following checklist will help to ensure you provide the required information and documentation that must be enclosed with your signed application.

Failure to provide the required documentation may cause your application to be delayed or voided.

- ☐ Read over the "MSU Financial Assistance Help Guide" for understanding of what is required.
- ☐ Signed Application Certification form (page 4)
- ☐ Signed Doctor Certification form (page 5)
- ☐ Front Page of Most Recent Savings Account Statement with Average Daily Balance noted.
- ☐ Latest copies of bills and other supporting documents, up to $1,000 – as pertinent to application.
- ☐ Travel Details/Information letter – recommended if requesting Medical Travel assistance
- ☐ Personal Statement – optional

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APPLICATION CERTIFICATION

I hereby certify that the information provided in this application is true and correct as of this date and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from Myositis Support and Understanding Association, Inc. and may result in civil liability. The applicant hereby allows Myositis Support and Understanding Association, Inc. to share this information to third parties to administer this application and releases Myositis Support and Understanding Association, Inc. from any and all liability that may arise from the sharing of this information to third parties to administer this application and payment under any award.

I understand it is my responsibility to ascertain if there are any other financial consequences of receiving this financial assistance. I understand that unless otherwise agreed upon, by separate written instrument, names of recipients of financial assistance awards will be kept confidential.

Anti-Discrimination Policy: MSU does not discriminate based on race, religion, color, age, national origin, gender, sexual orientation, or political affiliation.

All financial applications will be reviewed on a case-by-case basis and final determination will be based on eligibility, financial need, and availability of funds.

Dated this _____ day of _____, in the year _____

Patient/Applicant Name (print) _____

Patient/Applicant Signature _____

Relationship to the patient _____

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DOCTOR CERTIFICATION

This form, signed by your doctor, must accompany your application and supporting documentation.

I, _____ (circle: patient / legal guardian / power of attorney of)

(Print Full Name)

_____, DOB __ __/__ __/__ __ __ __ authorize the doctor and staff of the

(Name of patient, if differs from above)

facility or medical practice treating this patient to certify that said patient is currently receiving treatment for, or is in the process of being diagnosed with, a form of myositis (inflammatory myopathy), and is currently under their care.

Diagnosis: _____

Doctor Name (print) _____

Doctor Signature _____ Date_____

Name of Hospital/Medical Facility _____