MSU Myositis Support & Understanding
EMPOWERING THE MYOSITIS COMMUNITY

Name: _____

Date: _____

MSU Myositis Patient Financial Assistance Application

APPLICATION DETAILS

Use the Financial Assistance Help Guide (Help Guide) to assist with the application and to determine the supporting documents we require to review your application. Financial assistance is only available for residents of the U.S. Applications that are incomplete or missing required documentation may not be considered. Please allow at least 14 business days for review and processing of your application. To save on costs and help the environment, all notifications and finalized documents are sent via email. Be sure to check your spam email folder. If approved, myositis patients may receive up to $2,000.00 once per rolling year. **Full details are included in the Help Guide**.

Please print clearly, or type in the application fields below. Send completed and signed applications with supporting documents **by email to office@understandingmyositis.org**, or **by fax to 888-696-7273** or mail to MSU, 9125 N. Old State Road, Lincoln, DE 19960. **Do not send medical records.**

SECTION A: PERSONAL DEMOGRAPHICS, DIAGNOSIS, TREATING DOCTOR

Patient's Full Name _____ **Date of Birth** _____

Address _____

City, State, Zip _____

Email Address _____ **Phone** _____

Type of Myositis _____ **Treating Physician** _____

IF YOU ARE APPLYING ON SOMEONE ELSE'S BEHALF

Enter your information below and see the Help Guide for required documents.

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

_____

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Name: _____

Date: _____

SECTION B: HOUSEHOLD INCOME

Total Monthly Gross Household Income $_____

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

SECTION C: SAVINGS ACCOUNTS

☐ **Check here if your household does NOT have Savings Accounts**

Please list savings accounts in the spaces provided below. Include any fundraising accounts that have been established on your behalf. If needed, include additional accounts in a personal statement.

If you have savings accounts or personal fundraising accounts, please send us the most recent statement showing the average daily balance. We do not require the full statement. A printout of an online account is often sufficient, as long as it shows the average daily balance.

BANK NAME	AVERAGE DAILY BALANCE	ACCT. NO. (LAST 4 DIGITS)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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SECTION D: TYPE OF FINANCIAL ASSISTANCE REQUESTING

Select the type of financial assistance for which you are applying and enter the information requested in the appropriate section below. Please enter only the amount you are requesting, up to the maximum award of $2,000.00. ***See the Help Guide*** ***for full details, document requirements, additional forms, and answers to common questions.***

☐	**MEDICAL BILLS**	**Has insurance paid their part? *Y or N***	**AMT: _____**
☐	**EMERGENCY HOUSEHOLD EXPENSES**	**LIST THE TYPE OF BILL/EXPENSE:**	**AMT: _____**
☐	**MOBILITY DEVICE**	**ENTER THE NAME AND TYPE OF DEVICE:**	**AMT: _____**
DESCRIPTION OF DEVICE:			**Has insurance paid their part?** ***Y or N***

We encourage you to include a personal statement with your application if you think there is information not included on the application that would help us in the review, approval, and payment process.

MSU Myositis Support & Understanding
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Name: _____

Date: _____

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 or supporting documents will result in the loss of current and future assistance from Myositis Support and Understanding Association, Inc. (MSU) and may result in civil liability.

I hereby allow MSU to share my information with all necessary third parties in order to review, administer, verify, and make payments under any award and I release MSU from any and all liability that may arise from the sharing of my information with third parties.

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

I understand that MSU will send all notifications and official documents via email, including requests for further information and documents, and award determination letters, which you can save for your records. If you require a mailed copy, you can make a request via email or by notating such on your application or in your personal statement.

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

Anti-Discrimination Policy: MSU does not discriminate based on race, color, age, religion, national origin, gender, gender expression, sexual orientation, national origin (ancestry), marital status, disability, or political affiliation.

By signing and submitting this application, you acknowledge that you have read and agree to all of the information and terms included in this application and in the MSU Financial Assistance Application Help Guide.

Dated this _____ day of _____, in the year _____

Patient/Applicant Name (print) _____

Patient/Applicant Signature _____

Relationship to the patient _____

MSU Myositis Support & Understanding
EMPOWERING THE MYOSITIS COMMUNITY

Name: _____

Date: _____

DOCTOR CERTIFICATION

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

I, _____ (circle: patient / legal guardian / power of attorney)
(Print the patient's full name)

_____, DOB __ __/__ __/__ __ __ __ , authorize the doctor and staff of
(Name of patient, if differs from above)

the 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 type or subtype of idiopathic inflammatory myopathy (myositis), and is currently under their care.

Diagnosis: _____ DX code: _____

Doctor's Name (print) _____

Doctor's Signature _____ Date_____

Name of Hospital/Medical Facility _____