



ACT for MS Participation Application

All assistance must be approved by the Distribution Committee for ACT for MS. Payment is made directly to the approved vendor selected by ACT for MS. All information will be kept confidential and will not be given to any outside source.

Please Print

Date: _____ DOB: _____

Name: _____

Address: _____

E-mail address: _____

Phone Number: _____

Name of Neurologist: _____

Name of Medical insurance: _____

ACT for MS provides financial assistance for certain products and services to clients whose annual income is below \$36,000.

Is your **individual** income below \$36,000 per year? Yes _____ No _____

****If yes, proof of income is required.** (The front page of your most recent tax return or verification of SSI or Social Security Disability benefit.)

If yes: (Please check **all** sources of your individual income.):

- Wages and salaries
- Social Security, SSI, SSP
- Disability payments
- Workers' compensation
- Unemployment benefits
- Insurance settlements
- Profit from self-employment
- Other

I state the information I have provided in this application is true and correct.

Print Name: _____

Signature: _____ Date: _____

Household

**Financial Assistance Application for
Payment of Electric/Air Conditioning Bills**

To request payment of summer electricity bills, **combined income of all adults living in your home must be below \$36,000 per year.** The definition of household income is all money from all sources, both taxable and nontaxable for all people living in my home.

Is your **household** income below \$36,000 per year? Yes _____ No _____

****If yes, proof of income is required.** (The front page of your most recent tax return or verification of SSI or Social Security Disability benefit.)

This includes but is not limited to the following:

Please check **all** sources of your household's income.

- ___ Wages and salaries
- ___ Social Security, SSI, SSP
- ___ Disability payments
- ___ Workers' compensation
- ___ Unemployment benefits
- ___ Insurance settlements
- ___ Profit from self-employment
- ___ Other

Number of persons living in my home: Adults: _____ Children: _____ Total: _____

I receive the medical baseline allocation from my utility company. Yes ___ No ___

I state the information I have provided in this application is true and correct. I agree to inform ACT for MS if I no longer qualify for assistance. If I am found to have falsified any of the information stated I will repay any funds that were paid on my behalf.

Print Name: _____

Signature: _____ Date: _____