Summer Comfort Application

Deadline: 5/31/2024 **(or as funds permit)**

Applicant's Name: ______________________________

Address (Street): ______________________________

City: ____________________ State: ________ Zip Code: ____________

Phone: ______________________________

Email: ______________________________

Briefly describe how you would use the air conditioner and how it would improve your quality of life:

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Employed: ☐ Occupation: ______________________________ Retired: ☐

Type of MS ______________________________

Date Diagnosed: ____________ Where/By: ______________________________

Provide evidence (required) of MS diagnosis (chart note, doctor's note or copy of MS medication box).

Financial Information (required)

Please mark "**0**" to those that do not apply:

Income/Source		**Expenses**	
SSI/SSDI	____________	Rent/Mortgage	____________
Work	____________	Food	____________
Family/ SNAP	____________	Utilities/Other	____________
Other Source	____________	Vehicle Exp.	____________
Total $	____________	**Total $**	____________

Do you have any asset, liability or other financial information you would like to include that is not outlined above?

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By signing below I certify the information provided to the MSSP is true and accurate. Furthermore, I have read this application and hereby submit it along with proof of my diagnosis. I understand this application is to be sent to either 10117 SE Sunnyside Rd., Suite 709, Clackamas, OR 97015, or emailed to programs@msoregon.org or faxed to 503 563-5995 by **May 31, 2024**. I grant permission for MSSP to use my name and photograph for program promotional purposes.

Signature: ______________________________ Date: ____________

MSSP Address: PO Box 16553, Portland, OR 97292-0553

www.msoregon.org • 503 297-9544 • fax 503 563-5995 • programs@msoregon.org

Application Instructions

Step 1: You must provide documentation of your MS diagnosis. This can be a medical chart note that includes your name and diagnosis, a doctor's note or a copy of the card board cover of one of the following medications:

Injectable Medications:

Avonex® (interferon beta-1a)

Betaseron® (interferon beta-1b)

Copaxone® (glatiramer acetate)

Extavia® (interferon beta-1b)

Glatiramer Acetate Injection (glatiramer acetate -generic equivalent of Copaxone 20 mg and 40 mg doses)

Plegridy® (peginterferon beta-1a)

Glatopa® (glatiramer acetate-generic equivalent of Copaxone) 20 mg and 40 mg doses)

Rebif® (interferon beta-1a)

Kesimpta® (ofatumumab)

Oral Medications:

Aubagio® (teriflunomide)

Bafiertam™ (monomethyl fumarate)

Dimethyl Fumarate (dimethyl fumarate-generic equivalent of Tecfidera)

Gilenya® (fingolimod)

Mavenclad® (cladribine)

Mayzent® (siponimod)

Ponvory™ (ponesimod)

Vumerity® (diroximel fumarate)

Zeposia® (ozanimod)

Infused Medications:

Lemtrada® (alemtuzumab)

Novantrone® (mitoxantrone)

Ocrevus® (ocrelizumab)

Tysabri® (natalizumab)

Step 2: Submit your completed application along with proof of diagnosis to 10117 SE Sunnyside Rd., #709, Clackamas, OR 97015, email to programs@msoregon.org or fax 503 563-5995. **May 31, 2024** is the application deadline. For questions call 503 297-9544.