



Angels Hearts for Hope Foundation Assistance Program Grant Application

Mission Statement:

To empower individuals with Multiple Sclerosis to overcome adversity and realize their full potential.

[Angels Hearts for Hope](#)

Grant Application Period (While Funds Last)

- Opens Each November 1st
 - Closes Each May 1st
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Application Process

To apply for assistance, individuals must submit the following documentation:

1. Proof of MS Diagnosis

A letter or medical record from a treating physician confirming a diagnosis of Multiple Sclerosis.

2. Insurance Documentation

Proof of current insurance coverage or documentation confirming uninsured status.

3. Itemized Medical Bills

Copies of outstanding medical bills showing:

- Total amount owed
- Insurance adjustments
- Patient responsibility

4. Proof of Applicant Contribution

Applicants must contribute toward their requested medical expenses and provide proof of payment (receipts, bank statements, provider payment confirmations) for amounts up to \$500.

5. Personal Statement

A brief statement describing the applicant’s situation and how financial assistance would support continued treatment and care.

Applications are reviewed on a rolling basis. Applicants can expect a funding decision within approximately 7–10 business days after submission of a complete application.

Applicant Information

Date of Application: _____

Name of Individual Needing Assistance:

Mailing Address:

Street Address (if different):

Telephone: _____

Email: _____

Medical Information

Diagnosis: _____

Date of Diagnosis: _____

Current Treatment(s):

Financial Assistance Request

Angel Hearts for Hope provides financial assistance for medical expenses not typically covered by insurance. Applicants must demonstrate a financial need and provide proof of payment toward the requested expense.

Please explain your financial need:

Amount Requested: \$ _____

If requesting payment of medical bills, copies of the bills must be submitted. Requests will not be considered without sufficient documentation.

Payments are made directly to approved providers.

Provider Information

Applicant Name: _____

Provider #1

Provider Name: _____

Address: _____

Telephone: _____

Email: _____

Referral Information

How did you hear about Angels Hearts for Hope?

Media Release Authorization (Optional Recommended)

By signing below, I grant permission to Angels Hearts for Hope to use photographs, testimonials, or statements shared voluntarily by me for community awareness, promotional materials, events, and social media platforms.

I understand that participation is voluntary and not required for grant consideration.

Applicant Signature: _____

Date: _____

Non-Discrimination Policy: “Angel Hearts for Hope does not discriminate on the basis of race, color, religion, gender, age, disability, sexual orientation, or national origin.”