MISSISSIPPI PARALYSIS ASSOCIATION

Mailing Address: 350 W. Woodrow Wilson Avenue, Suite 130 Jackson, MS 39213

Office phone: 601.326.2654 **Fax: 601.665.4025**

Email.com: msparalysisassocjxn@gmail.com

ASSISTANCE POLICY GUIDELINES

The following Assistance Policy Guidelines will be strictly enforced in determining eligibility for assistance. Failure to follow them will result in denial of assistance. A copy of these guidelines should accompany each referral application given to the client.

1. Mississippi Paralysis Association (MPA), is a non-profit charity and is payer of last resort. All other funding resources should be exhausted before applying to MPA, for assistance. MPA, will require documentation from other available funding resources proving the client has applied for those services (i.e. copies of agency or organization application of services).

2. MPA, has a cap on funding. This cap is $5,000.00. Each client has a $5,000.00 cap whether it is for one item (i.e. power wheelchair, home or vehicle modifications, etc.) or 5 items**. Once a client has reached their individual $5,000.00 cap, they must wait 24 months from the date the last approved assistance was paid before they may apply to MPA, for services again.**

3. Every person referred to MPA, must have some form of paralysis to qualify for services. This paralysis may be caused by injury, illness, disease, or birth defect. A brain injury will sometimes qualify as causing paralysis. Documentation on a doctor's letterhead from the client's doctor is required. The documentation must state (a) the client's disability, (b) if the client has a form of paralysis and (c) describe the client's disability and limitations in detail. Any documentation less than what is required will not be accepted. A diagnosis written on a prescription pad is not acceptable.

4. MPA, will not modify vehicles 10 years old or older unless the equipment is fully transferable (i.e.) manual roll ramp, manual hand controls, etc.). Please do not submit requests for modifications for vehicles 10 years old or older. It is to the sole discretion of MPA's Board of Directors on if to approve vehicles as stated above. If applying for vehicle modifications, strictly follow the directions on page two (2) of this referral packet.

5. Any approved assistance that has not been completed within 6 months of the approval letter date will be placed inactive and funding will no longer be available. The client must reapply for consideration going through the complete application process again.

6. Referral Application Requirements as outlined on page two (2) of the referral packet must be strictly followed. If you have a question about the requirements of these policies, please call the MPA, office.

Revised 12/22/2016

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REFERRAL APPLICATION REQUIRMENTS

Please remember to send **all** the following items along with the completed referral application.

Note: Additional information may be required once the application is reviewed.

1. Documentation from other agencies/organizations – Mississippi Paralysis Association (MPA), is a payer of last resort. We need proof that you have exhausted all other resources before applying to MPA, for assistance. This includes copies of applications and approval/decline letters from other organizations you have applied to for assistance.

2. Doctor's diagnosis and statement of disability (must state disability, whether you have a form of paralysis, and describe your disability and functional limitations in detail). Prescription pad diagnosis will not be accepted. This documentation must be on a doctor's letterhead.

3. Doctor's prescription for service requested (attach separate sheet or prescription).

4. Submit at least two (2) itemized quotes with the cost of each item listed as prescribed by your doctor. You must obtain this documentation from separate vendors. **Note:** Obtaining these quotes is the responsibility of the referring agency, organization and or the client. ***If requesting vehicle modifications***, you must submit: (a) copy of the vehicle title, (b) current mileage of the vehicle, (c) mechanics statement of body, engine, and transmission condition. ***If requesting hone modifications***, only return the application and other required documentation to MPA, **do not send quotes**. MPA, will send someone to assess your home.

   Note: MPA, does not solicit quotes or bids.

5. Completed Referral Application Request for Service – **incomplete forms will not be considered.**

DO NOT FAX REFERRAL APPLICATION OR DOCUMENTATION

Revised 12/22/2016

MISSISSIPPI PARALYSIS ASSOCIATION, INC.

REFERRAL APPLICATION REQUEST FOR SERVICE

PERSONAL INFORMATION: (Including mailing address if different from street address)

PLEASE PRINT

Applicant's Name: First _____M. _____ Last _____

Address: Street _____City _____State _____Zip _____

Date of Birth: _____/_____/_____ Marital Status (M/S/D/W): _____Home Phone: (_____) _____

Social Security Number: _____-_____-_____Age: _____ Male: _____ Female: _____

Employed/Student: ( ) No ( ) Yes - Name of Employer or School: _____

Number of Persons in Household: _____ Total of all Household Income Sources: _____

INCOME RESOURCES AND/OR RECEIVED SERVICES FROM ONE OF THE FOLLOWING ORANIZATIONS:
(Mark an "X" In All That Apply)

Veteran _____
Personal Commercial Insurance _____
SSI (Medicaid) _____
SSDI (Medicare) _____
Workmen's Compensation _____
Living Independence for Everyone _____
Vocational Rehabilitation _____
State Independence Living (MDRS) _____
MDRS SCI/TBI Trust-fund _____
Other Agency or Organization _____
Name: _____

MEDICAL DISABILITY: Does applicant have some type of paralysis ( ) Yes ( ) No

(Attach medical documentation from physician describing the applicant's disability and functional limitations in detail.)

SERVICE REQUEST: Select one type of service per application. Please re-apply within 3-6 months for each service needed.

Type of Service: _____

Purpose: _____

REFERRAL SUBMITTED BY: (If submitted by application leave this section blank)

Name of Counselor: _____ Phone: (_____) _____

Organization: _____ Fax: (_____) _____

Medical Consent Release

I, _____, (Applicant) grant permission and consent for
(Print)
the release of the above information to the Mississippi Paralysis Association, Inc. (MPA), and give my permission for MPA, its representatives, and associates to discuss or exchange any personal information pertaining to my disability and/or request for assistance with any organizations, agencies, and medical professionals that would aid them in considering my referral application request for service.

Applicant's Signature: _____ **Date:** _____

Guardian's Signature: _____**Relationship:** _____

***Required only if applicant is a minor or a vulnerable adult unable to sign application ***

Revised 12/22/2016