Medical Supply Assistance Application Form

For Individuals Living with Progressive Supranuclear Palsy (PSP) and Their Care Partners

SECTION 1: Applicant Information

Full Name of Patient: _____

Date of Birth: _____

Diagnosis Date: _____

Care Partner's Full Name (if applicable): _____

Mailing/Delivery Address: _____

City / State / Zip Code: _____

Phone Number: _____

Email Address: _____

SECTION 2: Household and Financial Information

Number of People in Household: _____

Annual Household Income Range (check one):

☐ Under $25,000 ☐ $25,001–$50,000 ☐ $50,001–$75,000 ☐ Over $75,000

Is the applicant currently receiving any public assistance (e.g. Medicaid, SSI, SSDI)?

☐ Yes ☐ No If yes, please specify: _____

SECTION 3: Physician Diagnosis Certification

To be completed by a licensed physician

I certify that the individual named above has been diagnosed with Progressive Supranuclear Palsy (PSP), a progressive neurological disorder.

Physician's Name: _____

Medical License Number: _____

Practice Name / Affiliation: _____

Address: _____

Phone: _____

Signature: _____

Date: _____

SECTION 5: Share Your Story

Please help us understand your journey with PSP and how this support can help you. You may either:

☐ Upload a Written Story
(Attach a 1–2 page written story describing your situation, needs, and how PSP has impacted your life.)

☐ Submit a Video Story
(Provide a link to a video or upload file: _____)

SECTION 6: Authorization and Consent

By signing below, I authorize the use and sharing of my (or the patient's) story and application details (excluding financial or medical identifiers) with donors, program partners, or on public platforms to raise awareness and support for PSP assistance programs. I understand this may include images, written or video submissions, and non-confidential portions of this application.

☐ I authorize the use of the story and details as described above.

☐ I do not authorize the use of our story publicly but consent to use for internal program review.

Signature of Patient or Legal Representative: _____

Name (printed): _____

Relationship to Patient (if applicable): _____

Date: _____

Submission Instructions

- Attach any required documents (physician certification, story submission).

- Submit this application via email to: tff@tomfisherfoundation.org

- OR mail to: P.O BOX 177 Zephyrhills Fl 33539

For questions or help with this form, contact us: Kelsey Fisher at 813-997-1374