



706 Haddonfield Road
Cherry Hill, NJ 08002
1-800-532-7667 msaa@msassociation.org

**MULTIPLE SCLEROSIS
ASSOCIATION OF AMERICA**

Breaking Down Barriers

Building Up Hope

MSAA COOLING PROGRAM APPLICATION

Why is cooling important to people with multiple sclerosis?

Many people with multiple sclerosis are heat sensitive. MS research has proven that heat and humidity often aggravate common MS symptoms. MS research has also proven that cooling the body can help lessen the negative effects of heat and humidity on a person with MS.

How do you cool the body?

You can cool the body by wearing various types of clothing apparel which have been specially adapted to provide a cooling effect. The most common products include: vests, neck collars, and wrist wraps. These products hold frozen ice packs in pockets or pouches. MS clients who wear these garments often experience temporary cooling relief which allows them to spend a few hours outdoors when the weather turns warmer.

What does the MSAA Cooling Program offer?

MSAA has assembled **Cooling Kits which include a vest, neck collar, set of wrist bands, and an extra set of ice packs.** These three products will cool the primary points on the body. Qualified MSAA clients can select **ONE Cooling Kit** and have the option to select **ONE Cooling Accessory.**

How do I apply for cooling products?

To receive cooling products, you must complete steps 1 thru 5 and return all required documents to MSAA.

Step 1 Complete the Personal Data Form (separate sheet)

Step 2 Complete the Income Eligibility Section

Step 3 Complete the Cooling Application

Step 4 **Get a prescription or letter from your doctor that verifies your diagnosis of MS and include it with this application**

Step 5 Read and sign the Cooling Equipment Terms Agreement Form

Complete & Return the following pages to MSAA *along with your doctor's note that verifies your MS and the Personal Data Form (separate sheet)*

MSAA COOLING PROGRAM APPLICATION FORM

Name: _____ Phone: (____) _____ Date: _____

Address: _____

INCOME ELIGIBILITY

Part A. YEARLY FAMILY INCOME is defined as all disability/pension income from the person with MS and all earned wages from his/her spouse/partner for the previous calendar year. Income from adult children and/or seniors living in the home is excluded.

My Yearly Family Income is: \$_____.

The total number of people living in my household is: _____.

Part B. Based on the information above, check the chart to see if your income is below the listed amount. If so, proceed to Part C and continue the application.

Example: Mary Smith has MS. She lives with her husband and daughter. Thus, there are 3 people in the household. Mary and her husband's combined Yearly Family Income is \$46,000. This is less than \$52,800 listed on the chart, so she qualifies.

MSAA's Yearly Family Income Guidelines (based on 3x the federal poverty level)

Persons living in the Household	Income
1	\$31,200
2	\$42,000
3	\$52,800
4	\$63,000
5	\$74,400
6	\$85,200
7	\$96,000
8	\$106,000

Part C. Please Sign Below:

By my signature below, I (the applicant) hereby certify that the information provided to MSAA is true and accurate to the best of my knowledge. I also understand that MSAA has the right to request written income verification if needed and/or deny this application if the required information and signature are not provided or the income exceeds our limits.

Signature: _____

Date: _____



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MSAA COOLING EQUIPMENT TERMS AGREEMENT FORM

By my signature below, I (the recipient) of this equipment understand and agree:

1. That the Multiple Sclerosis Association of America, Inc (MSAA) is not obligated to provide any or all of the equipment/items I have requested. MSAA retains the right to make the final determination on which equipment to distribute.
2. That some equipment is restricted to size, therefore the MSAA is neither responsible nor liable for fitting the requested equipment to me.
3. That upon receipt of equipment, I will inspect the equipment and notify MSAA of any problems or damage that may have occurred during shipping.
4. That I will release and hold harmless MSAA, its officers, employees, agents and members from any injury(ies) or loss(es) that may occur from the use or misuse of the equipment/items provided by MSAA.
5. That the equipment distributed to me will become my sole responsibility, and that all maintenance, repairs and replacements are my responsibility.
6. That I am responsible for notifying the MSAA of any name, address or telephone number changes that occur while I am in possession of any equipment belonging to MSAA.
7. That the personal and medical information I have voluntarily provided to MSAA may be used or shared for the sole purpose of acquiring the service or benefit I have requested. I understand MSAA's policy is to strictly maintain the confidentiality and security of all personal information.

I have read, understood and agreed with each of the terms and descriptions as stated above:

Name: (Please print or type) _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Signature: _____ **Date:** _____

If you have any questions, please call MSAA at 1-800-532-7667. Don't forget to return following:

- **A Prescription/letter from your doctor that verifies your MS**
- **A completed Personal Data Form (separate sheet)**
- **A completed Cooling Application which includes the Income Guideline, Product Selection, & Terms Agreement**

COOLING PHOTOS – DO NOT RETURN WITH APPLICATION

Kit A. Polar Poncho Style – Ice packs



Kit B. Polar Zipper Style – Ice packs (available in blue and khaki)



Kit C. Steele Zipper Style – Ice packs (available in blue and khaki)



Cooling Accessory – Cooling Pillowcase – Soft Ice Packs



Manufacturer Information

Polar Products
1-800-763-8423
www.polarsoftice.com

Steele Body Cooling
1-888-783-3538
www.steelevest.com

MSAA ID Number

Office Use Only

MSAA PERSONAL DATA

You are:

An Individual w/MS

A Care Partner

A Physician

Social Services Professional

Medical Professional

Friend or Relative of someone with MS

Other _____

Name _____

Address _____

City

County

State

Zip

Date of Birth _____ Female Male Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax _____ Email address _____

The return of this form enables you to apply for all MSAA programs and services and to receive a free, ongoing subscription to the MSAA quarterly magazine, *The Motivator*. If you do not wish to receive *The Motivator*, please check the box below.

I do not wish to receive the MSAA quarterly magazine, *The Motivator*.

I do not wish to receive MSAA emails.

How did you learn about MSAA?

Neurologist

Primary Care Physician

Other HealthCare Providers

Social Services Professional

Other MS organizations

MSAA Client

MSAA Activity

MSAA Publication

Motivator

Friend/Family

Pharmaceutical Company

Internet

Phone Book

Volunteer

Media

Fundraising Call

Fundraising Letter

Do not recall

If you have MS, please enter additional information on the back of this form.

For assistance in completing this form or for more information on MSAA programs and services, please contact one of our Helpline Consultants at 800-532-7667.

Important Note:

MSAA's policy is to strictly maintain the confidentiality and security of all personal and medical information. MSAA will use the personal and medical information, which has been voluntarily provided, only to assist in acquiring requested services or benefits. MSAA will not share names or other individually identifiable health information unless it is necessary to acquire a requested service or benefit.

Please return this form to:

**The Multiple Sclerosis Association of America
706 Haddonfield Road
Cherry Hill, New Jersey 08002**

800-532-7667

EMAIL ADDRESS: msaa@msassociation.org

WEB SITE ADDRESS: www.msassociation.org

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MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification:	Benign Relapsing/Remitting	Secondary Progressive Progressive Relapsing	Primary Progressive Unclear diagnosis	
Year Diagnosed:	_____			
Other Conditions:	_____			
Wheelchair Use:	None	Occasional	Moderate	Always
Assistive Devices:	Cane	Crutches	Walker	Scooter
	Other: _____			

Symptom <i>(check all that trouble you)</i>	Fatigue	Loss of Memory and Attention	Depression	Headaches
	Tingling	Difficulty with Problem Solving	Balance Difficulty	Speech Difficulty
	Numbness	Bladder Problems	Coordination Loss	Swallowing Difficulty
	Burning Sensation	Bowel Problems	Leg Heaviness	Heat Sensitivity
	Pain	Vision Loss/Blur	General Weakness	Cold Sensitivity
	Muscle Spasms		Tremors	Other Symptoms
	Muscle Tightness		Dizziness/Vertigo	

Tests you've had:	MRI [Brain]	MRI [Spine]	Spinal Tap	Evoked Potentials		
MS drugs you use:	Avonex®	Betaseron®	Copaxone®	Novantrone®	Rebif®	Tysabri®
	Other: _____					
Are you currently involved in a clinical trial?	Yes	No				
If yes, please list location: _____						

Ethnic Origin: (optional)	
American Indian or Alaska Native	Hispanic or Latino
Asian	Native Hawaiian or Other Pacific Islander
Black or African American	White
Chicano or Mexican American	Other (please specify): _____

Annual Income <i>(for family living in primary domicile)</i>	
Less than \$10,000	\$60,001 to \$70,000
\$10,001 to \$20,000	\$70,001 to \$80,000
\$20,001 to \$30,000	\$80,001 to \$90,000
\$30,001 to \$40,000	\$90,001 to \$100,000
\$40,001 to \$50,000	More than \$100,000
\$50,001 to \$60,000	

PLEASE LIST:

Primary Care Physician: _____ Phone: () _____

Address: _____

Neurologist: _____ Phone: () _____

Address: _____