



706 Haddonfield Road  
Cherry Hill, NJ 08002  
1-800-532-7667  
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**MULTIPLE SCLEROSIS  
ASSOCIATION OF AMERICA**

*Breaking Down Barriers*

*Building Up Hope*

## **MSAA EQUIPMENT DISTRIBUTION PROGRAM Application For Manual Mobility Items**

This application covers the following manually operated mobility items:

- Walker
- Companion/Transport Chair  
(must be pushed by care partner)
- Manual Wheelchair

### **Important Notes:**

- You may apply for **ONE (1)** of the manual mobility items offered through MSAA.
- There is a **THREE (3)** year waiting period before reapplying for another manual mobility product.
- Please select carefully as there are no exchanges or returns.

To receive a walker, companion chair, or manual wheelchair, **you must complete** steps 1 thru 6 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 Manual Mobility Application Form

**Step 4** Get a prescription or letter from your doctor that confirms your MS condition

**Step 5** Have the doctor indicate your medical need for the requested item on the prescription ( i.e., patient requires a .....)

**Step 6** Read and sign the Equipment Terms Agreement Form

The Income Guidelines only apply to the following MSAA programs: Cooling Distribution, Equipment Distribution, MRI Institute, MRI Diagnostic, and Therapeutic Services. MSAA encourages all interested individuals to return the Personal Data Form and become a member. This will enable you to receive *The Motivator* magazine, publications, and other available services.

**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 MANUAL MOBILITY ITEMS 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	\$63,600
5	\$74,400
6	\$85,200
7	\$96,000
8	\$106,800

**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: \_\_\_\_\_

# MSAA MANUAL MOBILITY ITEM APPLICATION FORM

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

## SELECT YOUR ITEM

You may select **ONE (1)** item from the list below. Please check the appropriate box. You are responsible for maintenance, repairs, and other replacement parts.

Four-Wheeled Walker (has seat & basket) – weight capacity 250 lbs.

Companion/Transport Chair (must be pushed by a care partner)

- Chair Weight: 19 lbs.; Weight capacity: 300 lb.

Manual Wheelchair (this also serves as a lightweight wheelchair)

A Pride Stylus wheelchair features an 18" width seat, removable wheels, and adjustable carriage.

Weight of chair: 19 lbs. when wheels are removed; Weight capacity: 250 lbs.

## MSAA 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 and weight, 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.
8. I have read, understood and agreed with each of the terms and descriptions as stated above:

Name: (Please print or type) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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](mailto:msaa@msassociation.org)

WEB SITE ADDRESS: [www.msassociation.org](http://www.msassociation.org)

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# MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

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

<b>Symptom</b> <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	

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

<b>Ethnic Origin:</b> (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): _____

<b>Annual Income</b> <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: \_\_\_\_\_