



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 EQUIPMENT DISTRIBUTION PROGRAM

Application For Safety, Mobility, and Daily Living Products

Individuals with MS can experience difficulty with balance and coordination, fine motor skills, and mobility. The MSAA Equipment Distribution Program offers clients a selection of products designed to improve safety, accessibility, and activities of daily living. MSAA provides these products at no charge to individuals with MS.

Many of the items offered through this program are specially adapted to help meet the needs of the physically challenged. A variety of assistive devices which are not covered in this program, such as reachers, bathtub mats, hand-held showers, etc., can be found at most national retail stores and home centers at a reasonable cost.

MSAA encourages clients to make careful selections based on their appropriate needs, as the set limitations apply for the length of a person's membership. All selections are final - no exchanges permitted. If you have questions, please call 800-532-7667.

To receive any of the items in this program, **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 Equipment Distribution Application Form
- 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 Equipment Terms Agreement Form

The Income Guidelines only apply to the following MSAA programs: Cooling Distribution, Equipment Distribution, and MRI Institute. 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 EQUIPMENT DISTRIBUTION APPLICATION FORM

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

Address: _____

INCOME ELIGIBILITY

Part A. YEARLY FAMILY INCOME is defined as all earned wages and other reported income (i.e. disability, pension, alimony, child support, etc.) from last calendar year for the person with MS **and** his or her spouse or partner living in the home.

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 \$54,930 listed on the chart for a family of three, so she qualifies.

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

Persons living in the Household	Income
1	\$32,490
2	\$43,710
3	\$54,930
4	\$66,150
5	\$77,370
6	\$88,590
7	\$99,810
8	\$111,030

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: _____

Please Make A Copy of This Form For Your Records 2

Revised: May 2010

PRODUCT SELECTIONS

Please make your selection(s) carefully as **THERE ARE NO RETURNS OR EXCHANGES**. Also, only **ONE selection allowed in Group A** – even if you choose to lessen or skip your selection from Group B – no exceptions.

Group A:

You may select **1** item from the list below. Please check the appropriate box and make your selection carefully, as the above limit is your maximum for this category.

- | | | |
|---|---|--|
| <input type="checkbox"/> Bathtub Transfer Bench (slide)
- up to 250 lb. capacity | <input type="checkbox"/> Shower Chair | <input type="checkbox"/> Bathtub Safety Rail |
| <input type="checkbox"/> Elevated Toilet Seat | <input type="checkbox"/> Walker with seat and four wheels | |

Group B:

You may select **2** items from the list below. Please check the appropriate box and make your selection carefully, as the above limit is your maximum for this category.

- | | | |
|--|--|--|
| <input type="checkbox"/> Grab Bar – 16" | <input type="checkbox"/> Hand Safety Rails | <input type="checkbox"/> Drinking Mug with handles |
| <input type="checkbox"/> Quad Cane
(small base) | <input type="checkbox"/> Easy-Grip Utensil Set
(<i>knife, fork, & 2 spoons</i>) | <input type="checkbox"/> Leg Lift |

Manual Wheelchair:

If you are interested in obtaining a standard, manual wheelchair through MSAA, you must first work closely with the Client Services Department. The MSAA staff will help determine if you are eligible to receive a manual wheelchair through outside resources such as, but not limited to, private insurance, Medicare/Medicaid, other organizations and support services.

To contact our Helpline staff, please call 800-532-7667 or email msquestions@msassociation.org.

Or, complete the information below and a member of the Client Services staff will contact you.

Name: _____ Phone: _____

Address: _____

Email: _____

MSAA PERSONAL 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 replacement parts/items are my responsibility.
6. That I am responsible for notifying the MSAA of any name, address or telephone number changes that occur while I possess any equipment provided by 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: _____

If you have any questions, please call MSAA at 1-800-532-7667.

- Don't forget to mail everything to MSAA**
- An Equipment Distribution Program Application Form
 - A Personal Data Form
 - **A Prescription/letter from your doctor that verifies your MS**
 - An Equipment Terms Agreement Form

Use the enclosed envelope or mail to:
MSAA
706 Haddonfield Road
Cherry Hill, NJ 08002

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

Revised April 2008

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: _____