



706 Haddonfield Road  
Cherry Hill, NJ 08002  
1-800-532-7667 [msaa@msassociation.org](mailto: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?**

The most common cooling product is a vest that contains insulated pockets which hold small ice packs. MS clients who wear these vests 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?**

The MSAA Cooling Program offers two different styles of cooling vests:

- 1. Vests that can be worn under clothing**
  - Holds fewer ice packs, resulting in less weight but less cooling time
- 2. Vests that can be worn over clothing**
  - Holds more ice packs, resulting in more cooling time but more weight

MSAA encourages you to consider these options and make your selection carefully as **there are no returns or exchanges**. Any questions, call MSAA at 800-532-7667 or the manufacturers on page 4.

### **How do I apply for cooling products?**

**To receive cooling vest, 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**

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



**D. –Steele Zipper Style** – ice packs must be frozen @ 32 degrees

**Must choose color:**       **Khaki**       **Blue (as shown)**



- **Worn over clothing**
- **Vest weight is 5.5 lbs. with all ice packs**
- **Adjustable – fits up to 275 lbs.**

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## **MSAA COOLING EQUIPMENT TERMS AGREEMENT**

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

**Manufacturer Information:**

**Polar Products**  
800-763-8423  
[www.polarsoftice.com](http://www.polarsoftice.com)

**Steele Body Cooling**  
888-783-3538  
[www.steelevest.com](http://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](mailto:msaa@msassociation.org)

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

Revised April 2008

# 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 <sup>®</sup>	Betaseron <sup>®</sup>	Copaxone <sup>®</sup>	Novantrone <sup>®</sup>	Rebif <sup>®</sup> Tysabri <sup>®</sup>
	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: \_\_\_\_\_