MULTIPLE SCLEROSIS ASSOCIATION OF AMERICA

375 Kings Highway North
Cherry Hill, NJ 08034
(800) 532-7667 msaa@mymsaa.org

Improving Lives Today

MSAA CHILDREN'S COOLING 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, although this research is based on adults diagnosed 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 which freeze at 32 degrees Fahrenheit. Individuals with MS who wear these vests often experience temporary cooling relief which allows them to enjoy the outdoors during the summer.

How does a children's cooling vest differ from standard cooling vests?

Size: Standard cooling vests come in adult sizes ranging from adult small to double extra-large. The children's cooling vests are designed to fit children and pre-teens up to 100 lbs.

Cooling: Rather than using ice packs which freeze at 32 degrees Fahrenheit, a children's cooling vest uses ice packs that freeze solid at a moderate, safe temperature of 58 degrees Fahrenheit. These cooling packs release their cooling energy at this consistent and comfortable temperature for up to three hours. They can be frozen in a freezer, refrigerator or bucket of ice water. Packs are non-toxic and non-flammable.

If you have additional questions about pediatric MS, please call MSAA at (800) 532-7667.

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 child's diagnosis of MS and include it with this application

Step 5 Read and sign the Cooling Equipment Terms Agreement

MSAA COOLING PROGRAM APPLICATION FORM

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Information:

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.

Our 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.

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

Persons living in the Household	Income
1	$35,010
2	$47,190
3	$59,370
4	$71,550
5	$83,730
6	$95,910
7	$108,090
8	$120,270

Part C. Please Sign Below:

By my signature below, I (the parent/guardian of 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: _____

PRODUCT SELECTION – Choose Only One Vest

Children's Zipper-Style Cooling Vest

- Worn over clothing. Adjustable at the shoulders, chest and waist.
- One size fits children up to 100 lbs. with a chest or waist circumference of 26" to 42". Vest length can be adjusted from 15.25" to 17.25".
- Vest weight is adjustable by varying the use of cooling packs. Weight is 2 lbs. (with 3 packs) and 2.75 pounds (with 4 packs). Cooling packs are 6" x 6".
- Includes Neck Collar (color will match vest selection).

Must choose color:

☐ **Polar Pink** ☐ **Arctic Blue** ☐ **Kodiak Khaki (not shown)**

MSAA COOLING EQUIPMENT TERMS AGREEMENT

By my signature below, I, the parent/guardian for 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 products I have requested. MSAA retains the right to make the final determination on which products to distribute.
2. That some products are restricted to size, therefore the MSAA is neither responsible nor liable for fitting 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: _____ **Signature:** _____ **Date:** _____

Manufacturer Information: **Polar Products - 800-763-8423; www.polarproducts.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 of the person with MS _____

Address _____

_____

_____

City County State Zip

Date of Birth _____ ☐ Female ☐ Male Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax _____ Email address _____

If under 18-years-old, please list the name of the patient's parent or guardian _____

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 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 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, please contact a 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
375 Kings Highway North
Cherry Hill, New Jersey 08034

1-800-532-7667 Fax 856-488-8257
EMAIL ADDRESS: msaa@mymsaa.org
WEB SITE ADDRESS: www.mymsaa.org

Revised 4/14

MSAA ID Number
Office Use Only
_____

MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification: ☐ Benign ☐ Secondary Progressive ☐ Primary Progressive ☐ Relapsing/Remitting ☐ Progressive Relapsing ☐ Unclear diagnosis

Year Diagnosed: _____

Other Conditions: _____

Wheelchair Use: ☐ None ☐ Occasional ☐ Moderate ☐ Always

Assistive Devices: ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Other: _____

Symptoms: *(check all that trouble you)*

☐ Fatigue ☐ Tingling ☐ Numbness ☐ Burning Sensation ☐ Pain ☐ Muscle Spasms ☐ Muscle Tightness
☐ Loss of Memory and Attention ☐ Difficulty with Problem Solving ☐ Bladder Problems ☐ Bowel Problems ☐ Vision Loss/Blur
☐ Depression ☐ Balance Difficulty ☐ Coordination Loss ☐ Leg Heaviness ☐ General Weakness ☐ Tremors ☐ Dizziness/Vertigo
☐ Headaches ☐ Speech Difficulty ☐ Swallowing Difficulty ☐ Heat Sensitivity ☐ Cold Sensitivity ☐ Other Symptoms

Tests you've had: ☐ MRI [Brain] ☐ MRI [Spine] ☐ Spinal Tap ☐ Evoked Potentials

MS drugs you use: ☐ Aubagio® ☐ Copaxone® ☐ Glatopa® ☐ Plegridy® ☐ Tecfidera ™ ☐ Avonex® ☐ Extavia® ☐ Lemtrada® ☐ Rebif ® ☐ Tysabri ® ☐ Betaseron® ☐ Gilenya® ☐ Novantrone®

Are you currently involved in a clinical trial? ☐ Yes ☐ No

If yes, please list location:
_____

Ethnic Origin: (optional)

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

Annual Income: *(for family living in primary domicile)*

☐ Less than $10,000
☐ $10,001 to $20,000
☐ $20,001 to $30,000
☐ $30,001 to $40,000
☐ $40,001 to $50,000
☐ $50,001 to $60,000
☐ $60,001 to $70,000
☐ $70,001 to $80,000
☐ $80,001 to $90,000
☐ $90,001 to $100,000
☐ More than $100,000

PLEASE LIST:

Primary Care Physician: _____ **Phone: ( )** _____

Address: _____

Neurologist: _____ **Phone: ( )** _____

Address: _____