Application for Safety, Mobility, and Exercise/Wellness 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, mobility, activities of daily living; along with exercise/wellness opportunities. MSAA provides these products at no charge to individuals with MS who qualify for assistance.

Many of the items offered through this program are specially adapted to help meet the needs of the physically challenged. Additionally, the exercise products are designed to help individuals participate in low-to-moderate level wellness activities.

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 Income Eligibility Section to see if you qualify

**Step 2** If you qualify, then make you product selection(s)

**Step 3** Read and sign the Terms Agreement Form

**Step 4** Complete the Intake Form

**Step 5** Get a prescription or letter from your doctor that verifies your diagnosis of MS and include it with this application

**Step 6** Return the completed application to MSAA via fax at 856-488-8257 or mail to: MSAA, 375 Kings Highway North, Cherry Hill, NJ 08034

The MSAA Equipment Distribution Program is made possible, in part, with support from the Virginia T. Dashiell Charitable Foundation, EMD Serono, and Genentech.
**STEP 1: 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 $52,000. This is less than $65,000 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)*

<table>
<thead>
<tr>
<th>Persons living in the Household</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$38,500</td>
</tr>
<tr>
<td>2</td>
<td>$52,000</td>
</tr>
<tr>
<td>3</td>
<td>$65,000</td>
</tr>
<tr>
<td>4</td>
<td>$79,000</td>
</tr>
<tr>
<td>5</td>
<td>$92,000</td>
</tr>
<tr>
<td>6</td>
<td>$105,500</td>
</tr>
<tr>
<td>7</td>
<td>$119,000</td>
</tr>
<tr>
<td>8</td>
<td>$132,500</td>
</tr>
</tbody>
</table>

**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: __________________________

**If you meet the income qualifications, please continue with Step 2.**
STEP 2: PRODUCT SELECTION

Please select carefully. You cannot skip an item in one group to double in another.

**Group A:** You may select 1 item from below. Please select carefully; there are no exceptions.

- Walker w/seat four wheels (250 lb. weight capacity)
- Transfer Bench (250 lb. weight capacity, reversible to fit all tubs)
- Bathtub Safety Rail (250 lb. weight capacity, call if you need > wt. limit)
- Shower Chair (250 lb. weight capacity)

**Group B:** You may select 1 item from below. Please select carefully; there are no exceptions.

- 16” Grab Bar
- Easy-Grip Utensil Set (knife, fork and 2 spoons)
- Quad Cane (small base)

**Group C - Exercise and Wellness Products:**
You may select 1 item from below. Please select carefully; there are no exceptions.

- Yoga Mat (blue) & DVD (counts as 1 item) - Please select one DVD listed below:
  - Gentle Yoga
  - Chair Yoga
- Exercise Peddler (low impact for legs & arms)
- Resistance Bands (set of 5) (Extra light to extra heavy)
MSAA also provides Manual Wheelchairs: If you need a standard manual wheelchair, please call MSAA’s Client Services Department at (800) 532-7667, ext. 154. MSAA will help determine if you are eligible for assistance through insurance or other resources prior to MSAA providing the wheelchair.

**STEP 3: 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. That I should consult my physician prior to the start or change to any exercise program or routine.

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

Name: (Please print or type): ______________________________________________

Signature: __________________________________________ Date: ______________

Please Make A Copy For Your Records
# STEP 4: INTAKE FORM

**Important Note:** MSAA’s policy is to strictly maintain the confidentiality and security of all personal and medical information. MSAA will not share your information unless it is necessary to acquire a requested service or benefit.

## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Last Name</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Shipping Address (if different)</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>City</td>
<td>____________________________ State: _____ Zip: _______ County: __________________</td>
</tr>
<tr>
<td>Home Phone</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Cell Phone</td>
<td>____________________________ ____________________</td>
</tr>
<tr>
<td>Email</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>____________________________ Gender: ____________ Marital Status: __________________</td>
</tr>
<tr>
<td>Primary care partner</td>
<td>_______________________________________________</td>
</tr>
</tbody>
</table>

**Race (please check all that apply):**
- [ ] American Indian or Alaska Native
- [ ] Asian or Pacific Islander
- [ ] Black or African American
- [ ] Hispanic or Latino
- [ ] White or Caucasian
- [ ] Other: __________________________________________

**Primary Language (please select one):**
- [ ] English
- [ ] Spanish
- [ ] Other: __________________________________________

**Referred to/learned about MSAA via (please select all that apply):**
- [ ] Family/Friend
- [ ] Healthcare Professional
- [ ] Internet Search
- [ ] Media
- [ ] MSAA Email
- [ ] MSAA Event
- [ ] MSAA Event Mailing
- [ ] MSAA Publication
- [ ] MSAA Website
- [ ] Other MS Organization
- [ ] Social Media
- [ ] Solicitation
- [ ] Swim for MS Brochure
- [ ] Swim for MS Partner
- [ ] Volunteer Match

If you wish to opt-out of MSAA’s free magazine or emails, please select below:
- [ ] Do not mail me *The Motivator* magazine.
- [ ] Do not send me MSAA emails.

## MS INFORMATION

**MS Classification (please select one):**
- [ ] Primary Progressive MS
- [ ] Relapsing Remitting MS

---

Please Make A Copy For Your Records  5 of 6  Revised: 1/20

MSAA Fax: 856-488-8257  MSAA Ph: (800) 532-7667
| __ Progressive Relapsing MS | __ Secondary Progressive MS | __ Unclear |

Year Diagnosed: _________________________

Symptoms (please list all that apply):

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

Mobility Issues:

- __ Always
- __ Moderate
- __ Occasional
- __ None

Are you currently taking a disease-modifying therapy (DMT) for MS?

- __ Yes
- __ No

If yes, please select your current treatment drug:

- __ Aubagio®
- __ Avonex®
- __ Betaseron®
- __ Copaxone
- __ Extavia®
- __ Gilenya®
- __ Glatopa®
- __ Lemtrada®
- __ Mavenclad®
- __ Mayzent®
- __ Novantrone®
- __ Ocrevus™
- __ ® Plegridy®
- __ Rebif®
- __ Tecfidera™
- __ Tysabri®

Tests (select all that apply):

- __ Evoked potentials
- __ MRI (brain)
- __ MRI (spine)
- __ Spinal tap

Primary care physician: __________________________ Phone: __________________________

Neurologist: __________________________ Phone: __________________________

Annual Family Income (estimate to the closest amount):

- __ Under $10,000
- __ $20,000
- __ $30,000
- __ $40,000
- __ $50,000
- __ $60,000
- __ $70,000
- __ $80,000
- __ $90,000
- __ $100,000+

Step 5: BE SURE TO INCLUDE PROOF OF YOUR MS DIAGNOSIS

Step 6: Return the completed application, with proof of MS diagnosis, to: MSAA via fax at 856-488-8257 or mail to 375 Kings Highway North, Cherry Hill, NJ 08034.