



Equipment Distribution Program Application
375 Kings Highway North, Suite B, Cherry Hill, NJ 08034
(800) 532-7667 Email: applications@mymsaa.org

All personal and medical information voluntarily provided to MSAA during the application process may be used or shared for the sole purpose of acquiring assistance through MSAA's services. MSAA's policy is to strictly maintain the confidentiality and security of all personal information.

Application for Safety, Mobility, and Exercise/Wellness Products

Individuals with MS can have trouble 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.

How do I qualify and apply?

- ✓ You have not received equipment from MSAA within the last 3 years.
- ✓ Meet Income Eligibility Requirement.
- ✓ Complete Intake Form.
- ✓ Make your product selection.
- ✓ Read and sign the Terms Agreement.
- ✓ Include a letter or a prescription to show proof of MS diagnosis.
- ✓ Return the completed and signed application to MSAA via fax at 856-488-8257 or mail to:

MSAA, 375 Kings Highway North, Suite B, Cherry Hill, NJ 08034

Email: applications@mymsaa.org

INCOME ELIGIBILITY

MSAA requests applicants to list their yearly family income based on their most recently filed income tax form. The listed income is compared to the chart below, which triples the federal poverty guidelines, to determine financial eligibility. MSAA utilizes Experian Health to verify income levels as part of the overall eligibility evaluation process. If you are income qualified, please visit our website to learn more about our MRI Program and Cooling Distribution Program at www.mysaa.org.

My Yearly Family Income is: \$_____.

The number of people in my household is: _____.

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

Persons living in the Household	Income
1	\$39,000
2	\$52,500
3	\$66,000
4	\$79,500
5	\$93,500
6	\$107,000
7	\$120,500
8	\$134,000

By my signature below, I (the applicant) hereby certify the information provided to MSAA is true and accurate and my yearly family income falls below the level listed in the chart per persons living in my household. I understand that I am providing 'written instructions' to MSAA under the Fair Credit Reporting Act authorizing MSAA to obtain information from my credit profile or other information from Experian Health. I authorize MSAA to obtain such information solely to verify income eligibility for MSAA's Equipment Distribution Program.

Signature: _____ **Date:** _____

INTAKE FORM

CONTACT INFORMATION

First Name: _____

Last Name: _____

Mailing Address: _____

Shipping Address (if different): _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Primary care partner: _____

Race (please check all that apply):

☐ American Indian or Alaska Native

☐ Hispanic or Latino

☐ Asian or Pacific Islander

☐ White or Caucasian

☐ Black or African American

☐ 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

☐ 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

☐ Progressive Relapsing MS

☐ Secondary Progressive MS

☐ Unclear

Year Diagnosed: _____

Symptoms (please list all that apply):

☐ Balance Difficulty

☐ Leg Heaviness

☐ Bladder Problems

☐ Loss of Memory and Attention

☐ Bowel Problems

☐ Muscle Spasms

☐ Burning Sensation

☐ Muscle Tightness

☐ Cold Sensitivity

☐ Numbness

☐ Coordination Loss

☐ Pain

☐ Depression

☐ Speech Difficulty

☐ Difficulty w/Problem Solving

☐ Swallowing Difficulty

☐ Dizziness/Vertigo

☐ Tingling

☐ Fatigue

☐ Tremors

☐ General Weakness

☐ Vision Loss/Blur

☐ Headaches

☐ Vision Pain

☐ Heat Sensitivity

☐ 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®

☐ Bafiertam™

☐ Betaseron®

☐ Copaxone

☐ Extavia®

☐ Gilenya®

☐ Glatiramer acetate

☐ Glatopa®

☐ Kesimpta®

☐ Lemtrada®

☐ Mavenclad®

☐ Mayzent®

☐ Novantrone®

☐ Ocrevus™

☐ Plegridy®

☐ Ponvory™

☐ Rebif®

☐ Tecfidera™

☐ Tysabri®

☐ Vumerity™

☐ Zeposia®

Tests (select all that apply):

☐ Evoked potentials

☐ MRI (brain)

☐ MRI (spine)

☐ Spinal tap

Primary care physician: _____ Phone: _____

Neurologist: _____ Phone: _____

PRODUCT SELECTION

Please select two (2) items below. Please select carefully as there are no returns.

☐ **Bathtub Safety Rail**



☐ **Easy-Grip Utensil Set**
(knife, fork and 2 spoons)



☐ **Exercise Peddler**
(low impact for legs & arms)



☐ **Grab Bar (16")**



☐ **Quad Cane**



☐ **Resistance Bands (set of 5)**



☐ **Deluxe Bath Bench with Back**
(250 lb. weight capacity)



☐ **Transfer Bench**
(250 lb. wt. capacity,
reversible handle)



☐ **Walker w/seat four wheels**
(250 lb. weight capacity)



☐ **Yoga Mat (blue) with a DVD (select 1)**
- Please select one DVD listed below:
_ Gentle Yoga _ Chair Yoga



Manual Wheelchairs Available on a Limited Basis: If you need a standard manual wheelchair, please call MSAA's Mission Delivery Dept. at (800) 532-7667, ext. 154. MSAA will help determine if you are eligible for assistance through insurance or other resources prior to MSAA approval. Limited availability.

TERMS AGREEMENT FORM

By my signature below, I (the recipient) of this equipment understand and agree that:

1. 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. Some equipment is restricted to size and weight, therefore the MSAA is neither responsible nor liable for fitting the requested equipment to me.
3. Upon receipt of equipment, I will inspect the equipment and notify MSAA of any problems or damage that may have occurred during shipping.
4. 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. The equipment distributed to me will become my sole responsibility, and that all maintenance, repairs and replacement parts/items are my responsibility.
6. 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. 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 should consult my physician prior to the start or change to any exercise program or routine.

Name: (Please print or type): _____

Signature: _____ **Date:** _____