



MULTIPLE SCLEROSIS
ASSOCIATION OF AMERICA

Improving Lives Today![™]

Equipment Distribution Program Application

375 Kings Highway North, Cherry Hill, NJ 08034
(800) 532-7667 Web: www.mymsaa.org

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 MSAA Equipment Distribution Program is made possible, in part, with support from Acorda Therapeutics, Bayer HealthCare and Biogen.

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 \$52,000. This is less than \$61,480 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	\$36,180
2	\$48,720
3	\$61,480
4	\$73,800
5	\$86,340
6	\$98,880
7	\$111,420
8	\$123,960

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: _____

PRODUCT SELECTIONS

Please make your selection(s) carefully. **There are no exchanges or returns.**
ONE selection allowed in Group A, even if you lessen or skip items in Group B.

Group A:

You may select **1** item from the list below. Please check the box carefully - there are no exceptions.

Walker w/seat and four wheels



Shower Chair



Bathtub Safety Rail



Group B:

You may select **2** items from the list below. Please check the box carefully - there are no exceptions.

Grab Bar – 16”



Quad Cane (small base)



Easy-Grip Utensil Set
(knife, fork, & 2 spoons)



Leg Lift



Hand Safety Rail



Manual Wheelchair – Limited Availability: If you are interested in receiving a standard manual wheelchair through MSAA, please call MSAA's Client Services Department at (800) 532-7667, ext. 154. A Client Service Specialist will help determine if you are eligible for assistance through insurance or other resources prior to MSAA purchasing the wheelchair through our Equipment Program.

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: _____

Please remember to:

- Complete the Equipment Distribution Program Application Form **and sign it**
- Complete the MSAA Personal Data Form **and include it**
- **Include a prescription/letter from your doctor that verifies your MS**

You May Return to MSAA by:

- Using the enclosed envelope
- Mailing to: **MSAA, 375 Kings Highway North, Cherry Hill, NJ 08034**
- **Faxing to: 856-488-8257 or Scanning and Emailing to: nmercado@mysaa.org**

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 MSAA Client Pharmaceutical Company Fundraising Call
 Primary Care MSAA Activity Internet Fundraising Letter
Physician
 Other HealthCare Providers MSAA Publication Phone Book Do not recall
 Social Services Professional Motivator Volunteer
 Other MS organizations Friend/Family Media

If you have MS, please enter additional information on the back of this form.

For assistance in completing this form, please contact a Helpline Specialist 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.

MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification:	<input type="checkbox"/> Benign	<input type="checkbox"/> Secondary Progressive	<input type="checkbox"/> Primary Progressive		
	<input type="checkbox"/> Relapsing/Remitting	<input type="checkbox"/> Progressive Relapsing	<input type="checkbox"/> Unclear diagnosis		
Year Diagnosed:	_____				
Other Conditions:	_____				
Wheelchair Use:	<input type="checkbox"/> None	<input type="checkbox"/> Occasional	<input type="checkbox"/> Moderate	<input type="checkbox"/> Always	
Assistive Devices:	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker	<input type="checkbox"/> Scooter	
	<input type="checkbox"/> Other: _____				
Symptoms: <i>(check all that trouble you)</i>	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of Memory and Attention	<input type="checkbox"/> Depression	<input type="checkbox"/> Headaches	
	<input type="checkbox"/> Tingling	<input type="checkbox"/> Difficulty with Problem Solving	<input type="checkbox"/> Balance Difficulty	<input type="checkbox"/> Speech Difficulty	
	<input type="checkbox"/> Numbness	<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Coordination Loss	<input type="checkbox"/> Swallowing Difficulty	
	<input type="checkbox"/> Burning Sensation	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Leg Heaviness	<input type="checkbox"/> Heat Sensitivity	
	<input type="checkbox"/> Pain	<input type="checkbox"/> Vision Loss/Blur	<input type="checkbox"/> General Weakness	<input type="checkbox"/> Cold Sensitivity	
	<input type="checkbox"/> Muscle Spasms		<input type="checkbox"/> Tremors	<input type="checkbox"/> Other Symptoms	
	<input type="checkbox"/> Muscle Tightness		<input type="checkbox"/> Dizziness/Vertigo		
Tests you've had:	<input type="checkbox"/> MRI [Brain]	<input type="checkbox"/> MRI [Spine]	<input type="checkbox"/> Spinal Tap	<input type="checkbox"/> Evoked Potentials	
MS drugs you use:	<input type="checkbox"/> Aubagio®	<input type="checkbox"/> Copaxone®	<input type="checkbox"/> Glatopa®	<input type="checkbox"/> Ocrevus™	<input type="checkbox"/> Tecfidera™
	<input type="checkbox"/> Avonex®	<input type="checkbox"/> Extavia®	<input type="checkbox"/> Lemtrada®	<input type="checkbox"/> Plegridy®	<input type="checkbox"/> Tysabri®
	<input type="checkbox"/> Betaseron®	<input type="checkbox"/> Gilenya®	<input type="checkbox"/> Novantrone®	<input type="checkbox"/> Rebif®	<input type="checkbox"/> Zinbryta®
Are you currently involved in a clinical trial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If yes, please list location: _____					

Ethnic Origin: (optional)	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White
<input type="checkbox"/> Chicano or Mexican American	<input type="checkbox"/> Other (please specify): _____

Annual Income: <i>(for family living in primary domicile)</i>	
<input type="checkbox"/> Less than \$10,000	<input type="checkbox"/> \$50,001 to \$60,000
	<input type="checkbox"/> \$60,001 to \$70,000
<input type="checkbox"/> \$10,001 to \$20,000	<input type="checkbox"/> \$70,001 to \$80,000
<input type="checkbox"/> \$20,001 to \$30,000	<input type="checkbox"/> \$80,001 to \$90,000
<input type="checkbox"/> \$30,001 to \$40,000	<input type="checkbox"/> \$90,001 to \$100,000
<input type="checkbox"/> \$40,001 to \$50,000	<input type="checkbox"/> More than \$100,000

PLEASE LIST:

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

Address: _____

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

Address: _____