



Multiple Sclerosis  
Association of America

**Equipment Distribution Program Application**  
375 Kings Highway North, Suite B, Cherry Hill, NJ 08034  
(800) 532-7667 Email: [applications@mymsaa.org](mailto: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.
- ✓ When making your product selection, please choose only 2 options.
- ✓ 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](mailto:applications@mymsaa.org)

## INCOME ELIGIBILITY

MSAA requests applicants to list their adjusted gross family income listed on their most recently filed income tax form. Your reported family income will be compared to the chart below to determine financial eligibility. MSAA utilizes Experian Health to verify income levels as part of the overall eligibility evaluation process.

My Yearly Family Income is: \$\_\_\_\_\_.

The number of people in my household is: \_\_\_\_\_.

### MSAA's Yearly Family Income Guidelines (based on the average federal poverty level up to 300%)

Persons living in the Household	Income
1	\$45,000
2	\$61,500
3	\$78,000
4	\$93,000
5	\$111,000
6	\$126,000
7	\$141,500
8	\$159,000

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 (the applicant) 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: \_\_\_\_\_

Race (please check all that apply)

American Indian or Alaska Native

Hispanic or Latino

Prefer not to answer

Asian or Pacific Islander

White or Caucasian

Black or African American

Other: \_\_\_\_\_

Primary Language (please select one)

English  Spanish  Other: \_\_\_\_\_

Referred to MSAA via (please select one)

Healthcare Professional

Social Media

MSAA Event

Internet Search

MSAA Publication

Unknown

Other MS Organization

MSAA Email

Other

Family/Friend

MSAA Website

**MS Classification:** (please select one)

Primary Progressive

Relapsing Remitting

Secondary Progressive

Unclear Diagnosis

Unknown

Not Diagnosed with  
MS/Suspected MS

Year Diagnosed: \_\_\_\_\_

Symptoms (please check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Balance Difficulty         | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Pain                  |
| <input type="checkbox"/> Bladder Problems           | <input type="checkbox"/> General Weakness         | <input type="checkbox"/> Speech Difficulty     |
| <input type="checkbox"/> Bowel Problems             | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Swallowing Difficulty |
| <input type="checkbox"/> Burning Sensation          | <input type="checkbox"/> Heat Sensitivity         | <input type="checkbox"/> Tingling              |
| <input type="checkbox"/> Cold Sensitivity           | <input type="checkbox"/> Leg Heaviness            | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Coordination Loss          | <input type="checkbox"/> Loss of Memory/Attention | <input type="checkbox"/> Vision Loss/Blur      |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Muscle Spasms            | <input type="checkbox"/> Vision Pain           |
| <input type="checkbox"/> Difficulty Problem Solving | <input type="checkbox"/> Muscle Tightness         | <input type="checkbox"/> Other Symptoms        |
| <input type="checkbox"/> Dizziness/Vertigo          | <input type="checkbox"/> Numbness                 | <input type="checkbox"/> N/A                   |

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:

- |                                    |                                     |   |                                      |                                    |
|------------------------------------|-------------------------------------|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Aubagio®  | <input type="checkbox"/> Avonex®    | <input type="checkbox"/> Bafiertam™         | <input type="checkbox"/> Betaseron®  | <input type="checkbox"/> Briumvi®  |
| <input type="checkbox"/> Copaxone® |                                     |   |                                      |                                    |
| <input type="checkbox"/> Extavia®  | <input type="checkbox"/> Gilenya®   | <input type="checkbox"/> Glatiramer acetate | <input type="checkbox"/> Glatopa®    | <input type="checkbox"/> Kesimpta® |
| <input type="checkbox"/> Lemtrada® | <input type="checkbox"/> Mavenclad® | <input type="checkbox"/> Mayzent®           | <input type="checkbox"/> Novantrone® | <input type="checkbox"/> Ocrevus™  |
| <input type="checkbox"/> Plegridy® | <input type="checkbox"/> Ponvory™   | <input type="checkbox"/> Rebif®             | <input type="checkbox"/> Tecfidera®  | <input type="checkbox"/> Tysabri®  |
| <input type="checkbox"/> Vumerity™ | <input type="checkbox"/> Zeposia®   | <input type="checkbox"/> Zunovo™            |                                      |                                    |

When did you start taking this DMT? Date started: \_\_\_\_\_

Tests You've Had: (select all that apply):

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

Care partner can speak on behalf of client in communications with MSAA?  Yes  No

Care Partner Name: \_\_\_\_\_

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