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 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 and the PNC Charitable Foundation.

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 $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	$36,420
2	$49,380
3	$62,340
4	$75,300
5	$88,260
6	$101,220
7	$114,180
8	$127,140

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 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 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**

☐ **Shower Chair**
(250 lb. weight capacity)*

*Call MSAA if you require a chair exceeding a 250 lb. wt. capacity.

Group B: You may select 2 items from below. Please select carefully; there are no exceptions.

☐ **Set of (2) 16" Grab Bars**
(counts as one item)

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

☐ **Quad Cane**
(small base)

☐ **Leg Lift**

Manual Wheelchair – Limited Availability: If you are in need of 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 providing the wheelchair through our Equipment Program.

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

Name: (Please print or type): _____

Signature: _____ Date: _____

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

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
__ 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
__ Progressive Relapsing MS
__ Relapsing Remitting 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®
__ 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 your MS diagnosis, to:**

MSAA via fax at 856-488-8257 or mail to 375 Kings Highway North, Cherry Hill, NJ 08034.