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

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 $60,270 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	$35,310
2	$47,790
3	$60,270
4	$72,750
5	$85,230
6	$97,710
7	$110,190
8	$122,670

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 as THERE ARE NO RETURNS OR EXCHANGES. Also, only ONE selection allowed in Group A – even if you choose to lessen or skip your selection from Group B – no exceptions.

Group A:

You may select **1** item from the list below. Please check the appropriate box and make your selection carefully, as the above limit is your maximum for this category.

☐ Bathtub Transfer Bench **(slide) - up to 250 lb. capacity**

☐ Shower Chair

☐ Bathtub Safety Rail

☐ Elevated Toilet Seat

☐ Walker with seat and four wheels

Group B:

You may select **2** items from the list below. Please check the appropriate box and make your selection carefully, as the above limit is your maximum for this category.

☐ Grab Bar – 16”

☐ Quad Cane (small base)

☐ Drinking Mug with handles

☐ Hand Safety Rail

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

☐ Leg Lift

Manual Wheelchair: ONLY COMPLETE IF YOU NEED A WHEELCHAIR

If you are interested in obtaining a standard, manual wheelchair through MSAA, you must first work closely with the Client Services Department. The MSAA staff will help determine if you are eligible to receive a manual wheelchair though outside resources such as, but not limited to, private insurance, Medicare/Medicaid, other organizations and support services.

To contact our Helpline staff, please call 800-532-7667 or email clientservices@mymsaa.org.

Or, complete the information below and a member of the Client Services staff will contact you.

Name:_____ Phone: _____

Address: _____

Email: _____

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:** _____

****

If you have any questions, please call MSAA at 1-800-532-7667.

Don't forget to mail everything to MSAA

- An Equipment Distribution Program Application Form
- A Personal Data Form
- **A Prescription/letter from your doctor that verifies your MS**
- An Equipment Terms Agreement Form

Use the enclosed envelope or mail to:
MSAA
375 Kings Highway N.
Cherry Hill, NJ 08034

MSAA ID Number
Office Use Only
_____

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

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

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

Please return this form to:

The Multiple Sclerosis Association of America
375 Kings Highway North
Cherry Hill, New Jersey 08034

1-800-532-7667 Fax 856-488-8257
EMAIL ADDRESS: msaa@mymsaa.org
WEB SITE ADDRESS: www.mymsaa.org

Revised 4/14

MSAA ID Number
Office Use Only
_____

MSAA PERSONAL DATA continued

For individuals with MS, please complete the following:

MS Classification: ☐ Benign ☐ Secondary Progressive ☐ Primary Progressive ☐ Relapsing/Remitting ☐ Progressive Relapsing ☐ Unclear diagnosis

Year Diagnosed: _____

Other Conditions: _____

Wheelchair Use: ☐ None ☐ Occasional ☐ Moderate ☐ Always

Assistive Devices: ☐ Cane ☐ Crutches ☐ Walker ☐ Scooter ☐ Other: _____

Symptoms: *(check all that trouble you)*

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

Tests you've had: ☐ MRI [Brain] ☐ MRI [Spine] ☐ Spinal Tap ☐ Evoked Potentials

MS drugs you use: ☐ Aubagio® ☐ Copaxone® ☐ Glatopa® ☐ Plegridy® ☐ Tecfidera ™ ☐ Avonex® ☐ Extavia® ☐ Lemtrada® ☐ Rebif ® ☐ Tysabri ® ☐ Betaseron® ☐ Gilenya® ☐ Novantrone®

Are you currently involved in a clinical trial? ☐ Yes ☐ No

If yes, please list location:
_____

Ethnic Origin: (optional)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Chicano or Mexican American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other (please specify): _____

Annual Income: *(for family living in primary domicile)*

☐ Less than $10,000
☐ $10,001 to $20,000
☐ $20,001 to $30,000
☐ $30,001 to $40,000
☐ $40,001 to $50,000
☐ $50,001 to $60,000
☐ $60,001 to $70,000
☐ $70,001 to $80,000
☐ $80,001 to $90,000
☐ $90,001 to $100,000
☐ More than $100,000

PLEASE LIST:

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

Address: _____

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

Address: _____