

THE ALS ASSOCIATION WISCONSIN CHAPTER BRIAN TRINASTIC MEMORIAL GRANT PROGRAM

The Brian Trinastic Memorial Grant Program assists with the needs of those individuals living with ALS. The Chapter does not receive federal or state funding. The Grant Program is solely funded through private donations, memorials, Chapter sponsored and Community/Family events.

Eligibility Criteria:

- **The applicant must have a definitive or probable diagnosis of ALS.**
- **The applicant must register with the Wisconsin Chapter and reside in the Chapter service area or receiving care through the ALSA Certified Clinic at Froedtert Hospital/MCW.**

Grants will be awarded monthly and **are based on available funds. First-time applicants may be given priority.**

Grant amounts vary depending upon type:

Transportation Grant - \$250 (may apply for and receive four grants every 12 months)

Flex Grant - \$500 (may apply for and receive two grants every 12 months)

Possible Grant Uses*

Transportation

Travel costs incurred due to ALS:
i.e. mileage/ transport service/van rental;
one night lodging related to
medical clinic appointment
or a Chapter event (i.e. symposium,
support group)

Flex

Home/Auto/Van Modifications, Modified van purchase,
Medical equipment/adaptive devices not covered
by medical insurance or out of pocket expense, ramps,
wheelchair/device batteries; communication devices,
apps, software and accessories

* This list is not all inclusive and is subject to change

Please Note: Eligible items must have been purchased within six months prior to grant approval or within six months following approval.

Contact Janet Gauger, Care Services Assistant if you have any questions or need more information:

414.831.3984 or janet@alsawi.org.

To be considered, the Grant Application must be received in our Chapter Office by midnight of the 20th day of each month. Late applications will be considered for the next grant cycle.

By mail:

The ALS Association Wisconsin Chapter
Attn: Janet Gauger
3333 N. Mayfair Road Suite 104
Wauwatosa, WI 53222

By fax:

414-231-9100

Scan and email to:

janet@alsawi.org

PHYSICIAN FORM
Verification of ALS Diagnosis

(This page should only be completed the first time you apply for a grant.)

To be completed by Patient / Caregiver

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Email _____

Contact person _____
Name Phone Number

To be signed by Neurologist specializing in ALS or Primary MD

By my signature, I verify that the above-named individual has received a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Probable/Possible ALS. I understand that this diagnostic designation affords this individual access to all the programs and services available through the ALS Association Wisconsin Chapter.

Physician Signature

Date

Print Name

Phone

Grant Application

Circle ONE choice only: **FLEX** **TRANSPORTATION**

I. Applicant Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell phone _____

Email Address _____

ALS Clinic Name _____ Neurologist Name _____

Date of Diagnosis _____ Date of birth _____

Veteran? ___ Yes ___ No If yes, Branch and Dates of Service: _____

Registered with VA? ___ Yes ___ No

II. Family Member or Primary Caregiver Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell phone _____

Email Address _____

Relationship to Patient _____

III. Please check levels of ability and disability

	<u>Total Care/Assist</u>	<u>With Assistance</u>	<u>No Help Needed</u>
Upper Body Limbs	___	___	___
Lower Body Limbs	___	___	___
Speech	___ Speech (unable to speak)	___ (Speech affected)	___ (Speech unaffected)
Eating / Swallowing	___	___	___
Breathing	___ (Ventilator)	___ (Bi-Pap)	___
Bathing	___	___	___
Toileting	___	___	___
Medications	___	___	___
Repositioning	___	___	___

Other information on patients' condition (continue on back side of this page if needed)

GRANT APPLICATION (continued)

VI. Additional Information

If applying for Transportation Grant, please answer the following:

Do you have free access (excluding gas) to an appropriate vehicle that meets your current transportation needs?

* YES NO If no, do you need to rent a: VAN or a CAR

Available Driver Information:

Lodging (over night stay)

* I have a driver that can drive me at no charge.

Attend clinic / medical appointment

I must hire a driver

Chapter event

Comments: (If for overnight lodging needs, please include type of medical appointment & date or Chapter event & date.)

*** If you have free access to a vehicle and a driver, please explain the specific need for this Transportation Grant***

If applying for the Flex Grant, please provide the following information:

What type of device / service / home / auto modification(s) do you need? **Please Note: eligible items or services must have been purchased or obtained no earlier than within six months prior to grant application.**

How will this device / service / home / auto modification(s) assist you? (Please check all that apply.)

Improve Independence

Improve Quality of Life

Improve Mobility

Additional comments or extenuating circumstances (continue on back side if more space needed): _____

**THE ALS ASSOCIATION – WISCONSIN CHAPTER
BRIAN TRINASTIC MEMORIAL GRANT PROGRAM**

POLICIES AND PROCEDURES*

The applicant must have a definitive or probable diagnosis of ALS. The applicant must register with the Wisconsin Chapter and reside in the Chapter service area or is receiving care through the ALSA Certified Clinic at Froedtert Hospital/MCW.

The Grant Application must be filled out in full to be considered.

First-time applicants must complete the Physician Form **including** Physician's signature.

Applications must be received on or before midnight of the 20th day of the month to be considered for a grant for the following month. Grant selections will be made between the 21st day and the last day of each month. Applicants will be notified of grant awards during the first week of the following month. **After** the grant is confirmed, grant recipients will receive direct reimbursement** for **eligible** expenses after submitting receipts/proof of payment with the signed Billing Statement for Reimbursement form. Transportation Grant travel reimbursement is on a per mile basis. Number of miles traveled along with dates and destination **must** be submitted to calculate reimbursement.

IMPORTANT: Eligible items/expenses including mileage are those that are incurred within six months prior to the grant application and within six months following grant approval or until grant expiration.

After receiving one grant from this program, applicants must reapply to be considered for subsequent grants. Please do not reapply for another grant (of the same type, i.e. Flex or Transportation) until you have submitted receipts for the previous approved grant and have utilized the entire grant award.

Grants must be used within six months after the Grant has been awarded. Expiration dates will be noted on the initial approval letter.

Applicants must sign and date this application and agree to the Policies and Procedures.

For any questions relating to the grant program, please contact Janet Gauger, Care Services Assistant at 414-831-3984 or janet@alsawi.org.

To the best of my knowledge and belief, the information I have provided on the Grant Application is true, correct, and complete. I have read the Grant Program Policies and Procedures and agree to abide by all requirements as noted.

Applicant (Print Name)

Date

Signature

Relationship to Patient
(if patient unable to sign form)

ALSA-WI Staff / Representative

Date Application Received

* Policies and Procedures are subject to change.

** You may be responsible for paying taxes on grant monies received. Consult your tax professional or the IRS for information.