ALS Association Massachusetts Chapter Quality of Life Grant Program

Request for Funds Packet

ELIGIBILITY REQUIREMENTS

1. Primary residence is in Massachusetts.
2. Registered with the ALS Association Massachusetts Chapter.
3. One-time completion of an ALS Verification Form signed by a neurologist.

IMPORTANT INFORMATION

- This is a reimbursement grant program. Only items as stated on the ALS Eligible Expenses List (pg.2), that you have already paid for during the current period, may be reimbursed ***up to the maximum amount of $500 per year.***
- You are not required to hold and submit receipts for the entire amount at one time (although you can request the total amount).
- ***All requests are subject to the availability of funds at the time of submission.*** Therefore, if partial reimbursement is initially received this does not guarantee you will receive the balance amount the second time you submit. WHY? This allows us to track budgeted grant funds more precisely which gets more funds to those who need it in a timely manner.
- Individuals receiving grants for the various purposes noted from the Association are for charitable purposes and the recipients show a need by meeting certain eligibility requirements. Need-based financial assistance is considered a gift under Section 102 of the Internal Revenue Code, provided that the recipient has not provided services in expectation of the assistance and provided that there is no expectation of future services (or any other quid pro quo) to or for the benefit of the provider. As such, need-based financial assistance is not compensation to, and no 1099 need be issued.

PLEASE FOLLOW THESE STEPS TO REQUEST FUNDS

Step 1 – Check ALS Eligible Expenses list (pg.2) to make sure receipt(s) you are submitting are:

1. On the list of qualifying expenses
2. Between the acceptable date ranges for current period

*If you are unsure, please contact your Care Services Coordinator before submitting.

Step 2 - Complete Request for Funds form (pg.3-4), answer impact questions, read and sign.
Step 3 - Attach Receipt(s). Include a denial of coverage from insurance company, if applicable.
Step 4 - Return by mail, email or fax (info provided on pg. 4) the completed Request for Funds form with receipt(s).
Step 5 - Wait for notification whether your request is being processed or funds are not available. If you have an email address on file, you will be notified by email or if not, by mail.
Step 6 – Receive check which can take up to 6 weeks. Checks are void after 90 days and cannot be re-issued. Please deposit when you receive.

Late requests cannot be accepted. See dates below.

IMPORTANT DATES TO REMEMBER

Grant Periods	Request for Funds form along with eligible receipts MUST be received by:	Receipts must be dated between:
1/1/2021 - 12/31/2021	**DEADLINE: 1/8/2022**	**January 1 and December 31 2021**

<u>ALS Eligible Expenses(all, but not limited to):</u> MUST NOT BE COVERED BY INSURANCE or BENEFITS

Please be sure to check this list before submitting your Request for Funds form.

- Accepted: Copies of invoices and/or receipts that clearly show detail of item(s)/services listed below
- Not accepted: Photos of receipts, copies of checks, cancelled checks, bank statements, credit card statements, insurance explanations of benefits (EOBs) or medical provider (portal) statements
- Please be sure these expenses are not covered by your insurance company
- The ALS Association cannot take responsibility for the quality or individual satisfaction of products or services you obtain.
- Some expenses will require a prescription or recommendation from a health care provider.

<u>Respite Care:</u>

- If care provider is not through a professional homecare agency, provider must complete the Respite Care Provider Log. This serves as your receipt. Attach to completed Request for Funds form.
- If care provider is through a professional homecare agency, attach a copy of invoice from professional provider to Request for Funds form.
  - Short-term, personal care of person with ALS, to relieve the primary caregiver. Respite care provider cannot live at the same address as the person living with ALS.

Communication: *As recommended by a Speech Language Pathologist/Occupational Therapist following AAC Evaluation*

- iPads/tablet (limit 1 per person) and communication apps
- Copays for speech generating devices (SGDs)

Medical Expenses: *as prescribed by a physician or healthcare provider*

- ALS clinic visits, genetic testing through ALS clinic
- Respiratory Care
- Nutritional Care
- Durable Medical Equipment
- Orthotic Devices: AFO braces, hand splints, Figure 8 sling, cervical collar
- Counseling (individual and/or family) by a licensed provider

Home Modifications:

- Materials and labor for home accessibility, grab bars, raised sinks, accessible toilet/seat riser, bidet, shower or bath modification, door widening, expandable door hinges, light switches, doorknobs, virtual assistant/ home automation systems (i.e. Alexa, Google Home)
- Generator (limit 1 per person)
- Portable or permanent ramps, platform lifts

Transportation:

- Rental of vehicle or car service to and from ALS clinic appointments, ME/NH/VT/MA clinical trial appointments (when travel stipend not provided), ALS connected medical treatments.
- Lodging for clinic appointment; 1 room for 1 night, limit up to $140/night, does not include meals.
- Automobile accessibility modification: wheelchair lifts, ramps, locking wheelchair mechanism, hand controls

Please speak with your Care Services Coordinator about financial options and resources

Needs Survey:

Please answer the following questions: On a scale of 1-5 with 1 being the lowest	1 – Not at all	2	3	4	5 - Tremendously
Having access to this grant will increase my quality of life:					
Having access to this grant will enable me to adapt to ALS changes:					
Having access to this grant will offset some of the financial burden of this disease:					

PLEASE REMEMBER: before applying, to serve as many and those who are most in need, please utilize alternative funding sources such as VA benefits, Medicare, Medicaid, Insurance coverage, Long Term Care insurance, etc. before requesting funds from the Northern New England Chapter. Veterans who are not receiving VA benefits should contact a veteran's service organization (PVA), clinic social worker or a member of the Chapter Care Services Department for guidance.

Please read the following before signing:

I have read the Request for Funds Packet and agree to abide by all requirements as noted.
By submitting this Chapter Request for Funds and signing below, I assume personal responsibility for understanding the Massachusetts Chapter Grant Request for Funds process, eligible expenses and deadlines (January 1st- December 31st, 2021). I also understand that no exceptions will be made to the grant deadlines and all grants are subject to availability of funds. I understand that policies and procedures are subject to change without prior notification.

_____

Applicant (Print Name)

_____ _____ _____

Signature Relationship to person with ALS Date

Please mail, email or fax completed forms to the Chapter office at:

The ALS Association Massachusetts Chapter
685 Canton St. Suite 103
Norwood, MA 02062
Email: Careservices@als-ma.org
Fax: 781-255-8811

Quality of Life Reimbursement Request Form

*This form must be completed & mailed, faxed or emailed with eligible receipts/forms for **each** reimbursement request*

Person Living with ALS Information: *(Note: Payment will only be made to pALS or Caregiver listed on the application)*

Name: _____ Date: _____

Address: _____City: _____State: _____Zip:

Phone: _____ Email:

Product/Service: _____ Requested Reimbursement Amount: _____

Check all that apply to this reimbursement

_____Respite _____ Transportation _____Medical Equipment Purchase/Repair

____Home Modification _____Personal Emergency Response System

_____ Other (Please Specify)

Please see the "Eligible ALS Expenses" list within application to ensure all receipts are acceptable.
**If you have not received a check within four weeks of submitting this form, you may contact your care services liaison @ 781-255-8884 or Careservices@als-ma.org to inquire about the status of your reimbursement. Please remember if you do not cash your check within 90 days, it will become void and cannot be reissued.*

Please fax, scan & email or mail this completed reimbursement request form with appropriate documentation) as stated on the "Eligible ALS Expenses" Form

The ALS Association Massachusetts Chapter
Attn: Care Services
685 Canton Street, Suite 103
Norwood, MA 02062
Fax: 781-255-8811 * Email: Careservices@als-ma.org

To be reimbursed, you must read and sign the "Eligible ALS Expenses" Form

FOR ALSA USE ONLY

Approved By: _____

Amount:_____

Date: _____