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 Kathleen Huevler, Care Services Assistant if you have any questions or need more information: 920-288-7095 or kathleen@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: Kathleen Huevler
3333 N. Mayfair Road Suite 104
Wauwatosa, WI 53222

By fax:
414-231-9100

Scan and email to:
kathleen@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

	Total Care/Assist	**With Assistance**	**No Help Needed**
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)

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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:

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

_____ I must hire a driver

Lodging (over night stay)

_____ Attend clinic / medical appointment

_____ 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***

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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.**

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____

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):______________

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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 Kathleen Huevler, Care Services Assistant at 920-288-7095 or kathleen@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.