Brian Trinastic Memorial Grant Program

ELIGIBILITY REQUIREMENTS

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

*People with ALS who do not live in Wisconsin, but attend Wisconsin clinic sites, will be eligible for this program. Other exceptions to the residency requirement will be made on an individual basis.

IMPORTANT INFORMATION

- This is a reimbursement grant program. Only items stated on the ALS Eligible Expenses (Page 2), that you have already paid for during the current period, may be reimbursed **up to the maximum of $1,000 per year.**
- You are not required to hold and submit receipts at one time. We encourage you to submit receipts as you incur the expenses.
- Reimbursement requests are subject to our availability of funds. Because this program relies on donations, we cannot guarantee reimbursement, but we will do our best to fill all requests. Our top priority is to provide assistance to our constituents, but we also need to be fiscally responsible, so funds are distributed equitably.
- 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 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 Form 1099 needs to be issued.

PLEASE FOLLOW THESE STEPS TO REQUEST FUNDS

Step 1: Ensure that you meet the three Eligibility Requirements outlined above.
Complete ALS Verification Form (Page 3).

Step 2: Check ALS Eligible Expenses (Page 2) to make sure receipt(s) you are submitting are:
1. On the list of qualifying expenses.
2. Between the acceptable date ranges for the current period.
*If you are unsure, please contact Kathleen Huevler (920-288-7095; kathleen@alsawi.org).

Step 3: Complete the Request for Funds form (Pages 4-5), read and sign.
Complete Mileage Log (Page 6), if applicable.

Step 4: Attach receipt(s). Include a denial of coverage from insurance company, if applicable.

Step 5: Return by mail, email, or fax (information provided on Page 5), the completed Request for Funds form with your receipt(s) and Mileage Log, if applicable.

Step 6: 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. We will otherwise notify by U.S. Postal Service.

Step 7: Receive check which can take up to six weeks. Checks are void after 90 days and cannot be re-issued. Please deposit when you receive.

IMPORTANT DATES TO REMEMBER (Late requests cannot be accepted.)

Grant Period	Request for Funds form along with eligible receipts **MUST** be **received** by:	Receipts must be dated between:
7/1/2021 - 12/31/2021	**DEADLINE: January 8, 2022**	**January 1 and December 31, 2021**

ALS ELIGIBLE EXPENSES: *Please check this list before submitting your Request for Funds form.*

- Must not be covered by insurance or benefits. Please be sure these expenses are not covered by your insurance company.
- Accepted: Copies of invoices and/or receipts that clearly show detail of item(s)/service(s) listed below.
- Not Accepted: Photos of receipts, copies of checks, cancelled checks, bank statements, credit card statements, insurance explanation of benefits (EOBs) or medical provider (portal) statements.
- 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.

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

- ➢ Tablet/iPad (limit 1 per person).
- ➢ Speech generating devices (limit 1 per person).
- ➢ Communication apps, software, and accessories.

Medical Expenses: *As prescribed by a physician or health care provider.*

- ➢ Durable medical equipment and equipment batteries.
- ➢ Orthotic devices: AFO braces, hand splits, slings, cervical collar.

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, clinical trial appointments (when travel stipend not provided), ALS related medical treatments, and chapter related events.
- ➢ Mileage for the above – must complete Mileage Log (see attached).
- ➢ Lodging for ALS clinic appointment or chapter related event: 1 room for 1 night, limit up to $140/night, does not include meals.
- ➢ Handicap accessible vehicle and automobile accessibility modifications: wheelchair lifts, ramps, locking wheelchair mechanism, hand controls.

ALS ASSOCIATION Wisconsin Chapter

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

Brian Trinastic Memorial Grant Program
Request for Funds Form

This form must be completed and mailed, emailed, or faxed with eligible receipts and/or Mileage Logs for *<u>each</u>* *reimbursement request submission. Pages 4-6 are required for reimbursement.*

Person Living with ALS Information:

Name: ______________________________ Date: ______________

Address: ______________________ City: __________ State: ______ Zip: ______

Phone: ______________________ Email: ______________________

Product/Service: ______________________________

____

Requested Reimbursement Amount: ______________________________

Check Payable To: ______________________ Relation to Person with ALS ______________

Check all that apply to this reimbursement:

Communication   Medical Expenses   Home Modifications   Transportation

Other (Please Specify):

____

Please see the "ALS Eligible Expenses" list to ensure all receipts are acceptable.

To be reimbursed, you must read, complete, and sign the following page.

FOR ALS ASSOCIATION USE ONLY	Approved By:
Amount:	Date:

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 most in need, please utilize alternative funding sources such as Medicare, Medicaid, VA benefits, insurance coverage, long term care insurance, etc.

Please read the following before signing:
I have read the Eligibility Requirements and ALS Eligible Expenses of the Brian Trinastic Memorial Grant Program. By submitting the Request for Funds form and signing below, I assume personal responsibility for understanding The ALS Association Wisconsin Chapter Request for Funds process, eligible expenses, and deadlines (January 1 – December 31, 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 and receipts to the Chapter office at:

The ALS Association Wisconsin Chapter
3333 N. Mayfair Road, Suite 104
Wauwatosa, WI 53222
Email: kathleen@alsawi.org
Fax: 414-231-9100

ALS ASSOCIATION
Wisconsin Chapter

Brian Trinastic Memorial Grant Program
Mileage Log

Travel Date	Miles Traveled	Description of Travel
Total Miles		
Reimbursement		**at 25 cents per mile**