ALS Care Grant Program

**Purpose:** To provide financial assistance to families living in the Northern Ohio Chapter service area with ALS or PLS to offset the increasing expenses experienced with such diseases.

**Eligibility:**
1. Must have a diagnosis of ALS or PLS and reside in The ALS Association Northern Ohio Chapter service area;
   a. Must provide verification of diagnosis of ALS or PLS diagnosis [ONE TIME ONLY (for first-time applicants)] by submitting a “Verification of Diagnosis” Form which must be completed by a neurologist who specializes in ALS or PLS.
2. Must use the grant to offset the financial burden of living with ALS or PLS to provide for needs such as equipment, care and/or services. Please refer to Grant Program Guidelines on page 4 for covered benefits. Some benefits may require a physician prescription.

**Eligibility Exceptions:** Grant requests made by recipients of Ohio Medicaid Home Care WAIVER or PASSPORT will be taken for consideration based on the following:
   a. Specific need that is not provided by the WAIVER or PASSPORT program; and
   b. Applicant consents to allow his/her Northern Ohio Chapter Care Services Coordinator to contact the WAIVER or PASSPORT case manager;
   c. Case-by-case basis, placed as second priority to applicants who are non-WAIVER or non-PASSPORT recipients.

**Eligibility Exclusions:** Veterans with ALS who are service-connected and eligible for VA benefits.

**Grant Offering:**
1. Up to $500.00 each cycle per applicant (refer to Grant Application Deadlines chart on page 3);
2. First-come, first-served;
3. A maximum of 50 grant applications will be approved each cycle (see Grant Application Deadlines chart). You may re-apply each cycle and are required to complete a new application each time.
4. Grant requests must be related to the diagnosis of ALS or PLS, such as equipment, care and/or services. Please refer to ALS Care Grant Program Guidelines on page 4 for covered benefits. Some benefits may require a physician prescription.
5. Grants will be paid as an expense reimbursement. The patient must first incur the expense then be reimbursed via the grant program.
6. If grant applications exceed budget funding for any given cycle, new applicants will take precedence over those who have already been approved for a grant, or have received respite reimbursement through the Founder’s Respite Program during the past 12 months.

**Disbursement:** Once approved, grants will be paid to the primary caregiver noted on the application, provided that all paperwork has been completed appropriately and receipts have been received by the office in accordance with stated deadlines.

For questions or more information, please contact the ALS Association office at:
216-592-2572/888-592-2572
Northern Ohio Chapter Service Area by County

Ashland         Lorain
Ashtabula       Lucas
Belmont         Mahoning
Carroll         Medina
Columbiana      Ottawa
Crawford        Portage
Cuyahoga        Richland
Defiance        Sandusky
Erie            Seneca
Fulton          Stark
Geauga          Summit
Harrison        Trumbull
Henry           Tuscarawas
Holmes          Wayne
Huron           Williams
Jefferson       Wood
Lake
Steps to Apply for the ALS Care Grant Program

***Please read instructions carefully***

Needs must be directly related to ALS or PLS diagnosis. For grant uses, please refer to the list of acceptable reimbursements in the ALS Care Grant Guidelines.

**Step 1:** Complete the application form on pages 5-6 and sign it.
*If this is your first time completing an application, you must submit a Verification of Diagnosis form (page 7) which must be completed by an experienced neurologist. If you are not sure you have a form on file in the Chapter office, contact the office at 216-592-2572/888-592-2572 or cathy@alsaohio.org.

**Step 2:** Once your application is received, you will receive a notification by email (or mail if there is no email address on file) stating that we’ve received your application. If you do not hear from us within two weeks, please contact your regional care coordinator.

*The cycle for which you are applying will be determined by the date you send your application.*
*Refer to Grant Application Deadlines chart below.*

**Step 3:** Once approved, begin saving your receipts that fall within the acceptable date ranges for the covered items/services (see chart below). Do not mail any receipts unless notified of approval. If approved, you will receive notification of your grant award, and instructions on how to submit receipts for reimbursement. Remember, only receipts that meet the guidelines on page 4 and that fall within acceptable date ranges below will be processed for reimbursement. All reimbursement requests require a completed Billing Statement for Reimbursement form to be returned with receipts. You will receive this form with your award notification.

*Note: We need copies of true receipts. Cancelled checks, credit card statements or bank statements are not acceptable.*

**Grant Application Deadlines**

*(Must be postmarked or time-stamped by midnight of the application deadline date listed below.)*

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Grant Application Deadline</th>
<th>Notification of Approval/Denial</th>
<th>Acceptable Date Range for Receipts</th>
<th>Receipts Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>January 20</td>
<td>Last week of January</td>
<td>October 21 - April 20</td>
<td>April 20</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>April 20</td>
<td>Last week of April</td>
<td>January 21 - July 20</td>
<td>July 20</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>July 20</td>
<td>Last week of July</td>
<td>April 21 – October 20</td>
<td>October 20</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>October 20</td>
<td>Last week of October</td>
<td>July 21 – January 20</td>
<td>January 20</td>
</tr>
</tbody>
</table>

**Step 4:** You may re-apply for the next grant cycle. Keep in mind that you have a 6-month window to submit qualifying receipts for each grant cycle (3 months before grant approval date and 3 months after grant approval date). Extensions will not be considered.
### ***PLEASE REVIEW GRANT REIMBURSEMENT GUIDELINES***

### ALS Care Grant Program Guidelines

#### ACCEPTABLE REIMBURSEMENTS

- Patient sitting services by anyone **NOT** living in the home.
- House cleaning, lawn/yard, or snow removal services.
  - Must be performed at patient's primary residence.

#### UNACCEPTABLE REIMBURSEMENTS (not all inclusive)

- Residential living - room and board fees.
- Caregiving provided by anyone living in the home.

**Traditional respite requests are handled through the Founders Respite Program.**

Contact your care services coordinator for more information.

Additional respite funds may be considered under this program, provided funding is available.

#### EXPANDED RESPITE

* Speech generating devices, which may include:
  - Desktop/laptop computer (**limited to 1 device**)
  - iPad or other similar tablet (**limited to 1 device**)
- Computer software or apps for communication (limits apply).
- Augmentative communication devices (**limited to 1 device**)

#### COMMUNICATION (medically necessary, physician prescription required)

<table>
<thead>
<tr>
<th>ACCEPTABLE</th>
<th>UNACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer repairs.</td>
<td>*Internet fees or phone bills.</td>
</tr>
<tr>
<td>*Speech generating devices, which may include:</td>
<td>*Televsions/Apple TV, cable connection, email service fees.</td>
</tr>
<tr>
<td>*Desktop/laptop computer (<strong>limited to 1 device</strong>).</td>
<td>*Virus protectors.</td>
</tr>
<tr>
<td>*iPad or other similar tablet (<strong>limited to 1 device</strong>).</td>
<td>*Computer table/desk, iPad/tablet/computer accessories.</td>
</tr>
<tr>
<td>*Computer software or apps for communication (limits apply).</td>
<td></td>
</tr>
<tr>
<td>*Augmentative communication devices (<strong>limited to 1 device</strong>).</td>
<td></td>
</tr>
</tbody>
</table>

#### MEDICAL EXPENSES, EQUIPMENT & SUPPLIES (medically necessary, physician prescription required)

<table>
<thead>
<tr>
<th>ACCEPTABLE</th>
<th>UNACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA approved Rilutek &amp; Nuedexta Only (no other medications).</td>
<td>Any over the counter or prescription medications (with the exception of Rilutek &amp; Nuedexta).</td>
</tr>
<tr>
<td>Diaphragm pacer co-payments &amp; supplies.</td>
<td>Dietary/Nutritional supplements, drinks, etc.</td>
</tr>
<tr>
<td>Durable medical equipment.</td>
<td>All Vitamins (prescribed and over-the-counter).</td>
</tr>
<tr>
<td>Clinic fees/co-payments.</td>
<td>Health insurance premiums.</td>
</tr>
<tr>
<td>PEG tube supplies/equipment (co-payments).</td>
<td>Any over the counter medical supplies.</td>
</tr>
<tr>
<td>Enteral Nutritional Formulas administered through PEG (co-payments).</td>
<td>Any type: clothing, groceries, toiletries, shoes, utensils, incontinence supplies, sheets, blankets, pillows/cushions.</td>
</tr>
<tr>
<td>Bipap/cPAP supplies (co-payments).</td>
<td>Utility bills (including alarm systems).</td>
</tr>
<tr>
<td>Medically necessary wheelchair upgrades, including cushions, seat lift elevator, head array, attendant controls, etc. (co-payments).</td>
<td>Non-ALS related doctor/hospital fees or co-payments (includes vision &amp; dental).</td>
</tr>
<tr>
<td>Prescribed aquatic therapy (co-payments).</td>
<td>Pool fees or equipment, exercise equipment.</td>
</tr>
<tr>
<td>Insurance co-payments for medical equipment.</td>
<td>Any adjustable bed or mattress, other than prescribed hospital beds/mattresses.</td>
</tr>
<tr>
<td>AFO braces/splints (co-payments).</td>
<td></td>
</tr>
<tr>
<td>Prescribed hospital beds &amp; mattresses (co-payments).</td>
<td></td>
</tr>
</tbody>
</table>

#### HOME MODIFICATIONS (medically necessary, physician prescription required)

<table>
<thead>
<tr>
<th>ACCEPTABLE</th>
<th>UNACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building of ramps or installation of lifts (material &amp; labor).</td>
<td>Home maintenance and repairs (including driveway and sidewalk repairs).</td>
</tr>
<tr>
<td>Bathroom accessibility (material &amp; labor).</td>
<td>Interior or exterior painting.</td>
</tr>
<tr>
<td>Doorway accessibility (material &amp; labor).</td>
<td></td>
</tr>
</tbody>
</table>

#### TRANSPORTATION (ALS or PLS MEDICAL USE ONLY)

<table>
<thead>
<tr>
<th>ACCEPTABLE</th>
<th>UNACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mileage to and from ALS Team Clinic, clinical study, ALS related medical appointments, such as pulmonary, gastroenterology, diaphragm pacer &amp; vent procedures.</td>
<td>Mileage to and from pharmacy, dental, vision or any medical appointments not listed on left.</td>
</tr>
<tr>
<td>Rental of vehicle and/or car service to get to and from ALS Team Clinic, clinical study, feeding tube, diaphragm pacer &amp; vent procedures appointments.</td>
<td>Purchase of any automobiles (including accessible van).</td>
</tr>
<tr>
<td>Adaptations for vehicles to make them accessible.</td>
<td>Automobile maintenance, including, but not limited to tire replacement, oil change, body, or engine repairs.</td>
</tr>
<tr>
<td>Lodging for ALS Team Clinic appointments.</td>
<td>Ambulance transportation.</td>
</tr>
</tbody>
</table>
  (1 room, 2 night limit; does NOT include meals) | |

### ALS Care Grant Program Application

Primary Caregiver must sign and date this application.
** ALS Care Grant Program Application **

Primary Caregiver must sign and date this application.

** Person with ALS or PLS Information **

Name: ____________________________

Physical Address (No P.O. Box): _____________________________________________

(Address MUST BE within the Northern Ohio Service territory, see list on page 2)

City: ____________________________ State: _______ Zip: ________________

Mailing Address (if different from Physical Address) ____________________________

City: ____________________________ State: _______ Zip: ________________

Phone: __________________________ Phone type: cell/landline E-mail address: ____________

Date of Diagnosis: _______________ Date of Birth: _______________

Veteran: Yes / No Ohio Medicaid Waiver or Passport Recipient: Yes / No

Household Income below 500% of Federal Poverty Level: Yes / No

Refer to enclosed chart for Federal Poverty Level Guidelines. Income verification required only if accepted.

ALS Clinic Name: ____________________________ Neurologist Name: ____________________________

Proposed Use of Funds, if approved: ____________________________________________

______________________________________________________

** Primary Caregiver Information ** (grants will be made payable to caregiver)

Name: ____________________________ Relationship to Patient: ____________________________

Address: __________________________________________

City: ____________________________ State: _______ Zip: ________________

Phone: __________________________ Phone type: cell/landline E-mail address: ____________

I understand that The ALS Association Northern Ohio Chapter ALS Care Grant Program is intended for use by those who truly need financial assistance. To the best of my knowledge and belief, the information I provided in the application is true, correct, and complete. I have reviewed the application materials and agree to abide by all requirements, as noted. I acknowledge that these grants are based on the availability of funds and that policies and procedures are subject to change.

** DO NOT SEND RECEIPTS WITH APPLICATION **

Applicant (Print Name) ____________________________ Date _______________

Signature ____________________________ Relationship to Patient ____________________________

Ohio Medicaid WAIVER and PASSPORT recipients only

I consent to allow my regional care coordinator contact my Ohio Medicaid WAIVER or PASSPORT case manager.

Name of Case Manager: ____________________________ Phone: ____________________________ Email: ____________________________

Patient or Power of Attorney signature ____________________________

Submit the Application to:

The ALS Association Northern Ohio Chapter
6133 Rockside Road, Suite 301
Independence, OH 44131
Fax: 216-592-2575
Email: alsicaregrant@alsaohio.org

Emailed applications are preferred. It is highly recommended that mailed applications are sent with tracking (i.e. USPS Priority Mail, UPS, FedEx).
Due to the decline in revenue as a result of the COVID-19 pandemic, The ALS Association Northern Ohio Chapter has implemented a family income eligibility requirement for the ALS Care Grant. Priority will be given to those whose household income is below 500% of the Federal Poverty Guideline. The 2020 Federal Poverty Guidelines can be found below. The 2021 Guidelines will be released around mid-January 2021.

<table>
<thead>
<tr>
<th>PERSONS IN FAMILY/HOUSEHOLD</th>
<th>POVERTY GUIDELINE</th>
<th>500% LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,760</td>
<td>$63,800</td>
</tr>
<tr>
<td>2</td>
<td>$17,240</td>
<td>$86,200</td>
</tr>
<tr>
<td>3</td>
<td>$21,720</td>
<td>$108,600</td>
</tr>
<tr>
<td>4</td>
<td>$26,200</td>
<td>$131,000</td>
</tr>
<tr>
<td>5</td>
<td>$30,680</td>
<td>$153,400</td>
</tr>
<tr>
<td>6</td>
<td>$35,160</td>
<td>$175,800</td>
</tr>
<tr>
<td>7</td>
<td>$39,640</td>
<td>$198,200</td>
</tr>
<tr>
<td>8</td>
<td>$44,120</td>
<td>$220,600</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $4,480 for each additional person.

If you have any questions, please contact a care coordinator at 888/216-592-2572.
This document must be signed by a neurologist who is experienced in ALS. Once this form is on file, you will not need to resubmit.

If you are not sure we have a verification of diagnosis form on file, please contact the Chapter office 216-592-2572/888-592-2572 or cathy@alsaohio.org.

To be completed by Patient or Caregiver:

Patient Name: __________________________________________________ _____________________________

Address (P.O. Box will not be accepted) _________________________________________________________

City ___________________________ State _________________ Zip __________________

Home Phone ___________________________ Cell Phone ______________________________________

Date of Birth ______________________________ Email __________________________________________

Neurologist Name: _________________________ Telephone: _____________________________________

Address: _______________________________ City: _____________ State: ___________ Zip: _______

Hospital or Clinic: _________________________________________________________________________

Must be signed by a Neurologist specializing in ALS or PLS:

By my signature, I verify that that the above named individual has a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Primary Lateral Sclerosis (PLS).

Circle one:  ALS        PLS

______________________________ (_____)___________________

Physician Name (Please Print)   Phone

______________________________

Physician Signature   Date

Completed form may be faxed to 216 592-2575 or emailed to alsaregrant@alsaohio.org