Grant Reimbursement Procedure

In order to receive your grant reimbursement check, the following procedures must be followed:

To maintain our ability to continue to fund the grant program, we must ask recipients to honor the Grant Application Deadlines chart below, as well as, the ALS Care Grant Reimbursement Guidelines.

Out of date receipts and receipts for unacceptable items will NOT be honored.

Thank you for your help and support.

Step 1. Complete the **Billing Statement Reimbursement form** (a copy is included along with the grant approval letter) and attach appropriate receipts.

*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>1st</td>
<td>January 20</td>
<td>Last week of January</td>
<td>October 21 - April 20</td>
<td>April 20</td>
</tr>
<tr>
<td>2nd</td>
<td>April 20</td>
<td>Last week of April</td>
<td>January 21 - July 20</td>
<td>July 20</td>
</tr>
<tr>
<td>3rd</td>
<td>July 20</td>
<td>Last week of July</td>
<td>April 21 – October 20</td>
<td>October 20</td>
</tr>
<tr>
<td>4th</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 2. To receive reimbursement for:

- **Travel Expenses**: Complete a **Mileage Log** (a copy is included with the grant approval letter) and **Billing Statement Reimbursement form**. We cannot accept gas receipts.
- **Services Provided** (example: home care): If an invoice/receipt is not provided to you by the service provider, complete a **Grant Service Receipt** (a copy is included with the grant approval letter). Service provider information and signature are required. Attach to a completed **Billing Statement Reimbursement form**.
- **Items purchased**: Attach a copy of the actual receipt(s) to the **Billing Statement Reimbursement form**. We cannot accept cancelled checks/copies of checks, bank statements or credit card statements.

Please NOTE: Grant checks will only be made payable to the designee listed on the Billing Statement Reimbursement Form.

Step 3. Send completed paperwork no later than the “Receipts Due Date,” based on the cycle for which you were approved, to the address listed on Billing Statement for Reimbursement form.

For questions or more information please contact:

Katie Price, Office Manager.
Toll free at 1-888-592-2572 or email at alsicaregrant@alsaohio.org

***PLEASE REVIEW GRANT REIMBURSEMENT GUIDELINES***
## ALS Care Grant Program Guidelines

**ACCEPTABLE REIMBURSEMENTS**

<table>
<thead>
<tr>
<th>EXPANDED RESPITE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Patient sitting services by anyone NOT living in the home.</em></td>
</tr>
<tr>
<td><em>House cleaning, lawn/yard, or snow removal services.</em></td>
</tr>
<tr>
<td>- Must be performed at patient’s primary residence.</td>
</tr>
</tbody>
</table>

**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.

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

- *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*).

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

- *FDA approved Rilutek & Nuedexta Only (no other medications).*
- *Diaphragm pacer co-payments & supplies.*
- *Durable medical equipment.*
- *Clinic fees/co-payments.*
- *PEG tube supplies/equipment (co-payments).*
- *Enteral Nutritional Formulas administered through PEG (co-payments).*
- *Bipap/cpap supplies (co-payments).*
- *Medically necessary wheelchair upgrades, including cushions, seat lift elevator, head array, attendant controls, etc. (co-payments).*
- *Portable ramps, generators.*
- *Prescribed aquatic therapy (co-payments).*
- *Insurance co-payments for medical equipment.*
- *AFO braces/splints (co-payments).*
- *Prescribed hospital beds & mattresses (co-payments).*

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

- *Building of ramps or installation of lifts (material & labor).*
- *Bathroom accessibility (material & labor).*
- *Doorway accessibility (material & labor).*

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

- *Mileage to and from ALS Team Clinic, clinical study, ALS related medical appointments, such as pulmonary, gastroenterology, diaphragm pacer & vent procedures.*
- *Rental of vehicle and/or car service to get to and from ALS Team Clinic, clinical study, feeding tube, diaphragm pacer & vent procedures appointments.*
- *Adaptations for vehicles to make them accessible.*
- *Lodging for ALS Team Clinic appointments.*
  - (1 room, 2 night limit; does NOT include meals)

- *Mileage to and from pharmacy, dental, vision or any medical appointments not listed on left.*
- *Purchase of any automobiles (including accessible van).*
- *Automobile maintenance, including, but not limited to tire replacement, oil change, body, or engine repairs.*
- *Ambulance transportation.*

*Computer repairs.*

*Internet fees or phone bills.*

*Televisions/Apple TV, cable connection, email service fees.*

*Virus protectors.*

*Computer table/desk, iPad/tablet/computer accessories.*

*Any over the counter or prescription medications (with the exception of Rilutek & Nuedexta).*

*Dietary/Nutritional supplements, drinks, etc.*

*All Vitamins (prescribed and over-the-counter).*

*Health insurance premiums.*

*Any over the counter medical supplies.*

*Any type: clothing, groceries, toiletries, shoes, utensils, incontinence supplies, sheets, blankets, pillows/cushions.*

*Utility bills (including alarm systems).*

*Non-ALS related doctor/hospital fees or co-payments (includes vision & dental).*

*Acupuncture/masses/massage therapy/ massage cushions/hand massagers.*

*Pool fees or equipment, exercise equipment.*

*Any adjustable bed or mattress, other than prescribed hospital beds/mattresses.*

*Home maintenance and repairs (including driveway and sidewalk repairs).*

*Interior or exterior painting.*
ALS Care Grant Program

Billing Statement for Reimbursement

Payee Designation (if other than patient) -- Reimbursement can only be made to the person listed below.

Patient Name: ________________________  Today’s Date: ________________________

Address: ___________________________________  City: __________________  State: __  Zip: ________

Phone: ___________________________________  Email: ________________________

Payee (if other than patient): ____________________________  Relationship to Patient: ____________________________

Address: ___________________________________  City: __________________  State: __  Zip: ________

---

FOR SERVICES BEING PROVIDED

Complete a GRANT SERVICE RECEIPT (if receipt is not provided to you by service provider) and attach to this completed form.

FOR TRANSPORTATION EXPENSES

Complete a MILEAGE LOG FORM and attach to this completed form, (we cannot accept gas receipts).

FOR PURCHASED ITEMS

Attach copy of actual invoice/receipts to this completed form (We cannot accept credit card statements, bank statements or copies of checks).

---

Quarter | Acceptable Date Range for Receipts | Receipts Due By
---|---|---
1st | October 21 – April 20 | April 20
2nd | January 21 – July 20 | July 20
3rd | April 21 – October 20 | October 20
4th | July 21 – January 20 | January 20

FOR ALSA USE ONLY

Amount: ________________________
Approved By: ________________________
Date: ________________________

Please note that it may take up to three weeks to receive a reimbursement check after sending this completed statement. If you do not receive a check from us within three weeks after sending this statement, you may contact Katie at 216-592-2572/888-592-2572 or email alscaregrant@alsaohio.org to inquire about the status of your reimbursement.

Please review reimbursement guidelines and acceptable date ranges before submitting.

By signing this form, I am agreeing to honor the date and reimbursement guidelines listed above.

Patient/Caregiver Signature: ________________________  Date: ________________________

Please send THIS completed Billing Statement form WITH appropriate paperwork as listed above to:

The ALS Association Northern Ohio Chapter
6133 Rockside Road, Suite 301
Independence, OH 44131
Phone: 216-592-2572/888-592-2572
Fax: 216-592-2575
Email: alscaregrant@alsaohio.org

---

For Office Use Only: Communication _______ Equipment _______ Transport/Lodging _______ Home Care _______
Home Modifications _______ Copay _______ Other _______

TOTAL SUBMITTED ____________________
**THE ALS ASSOCIATION – Northern Ohio Chapter**

**Grant Service Receipt (only if needed)**

*Instructions:* If service provider (driver, sitter, etc.) does not have their own billing receipt, please complete this Grant Service Receipt. Service Provider can be a company or individual. Please attach this receipt to Billing Statement for Reimbursement along with any other appropriate receipts.

**Patient Name:** ____________________________________________________________

**Patient/POA Signature:** _______________________________ **Date:** __________

**Service Provider Information (MUST BE COMPLETED/SIGNED BY SERVICE PROVIDER)**

**Name of Provider:** ________________________________________________________

**Address:** ______________________ City/State: _______________ Zip: __________

**Home Phone:** ______________________ **Cell:** ______________________

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Service Provided</th>
<th>Number of Hours</th>
<th>Hourly Rate</th>
<th>Total Paid</th>
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**Service Provider Signature:** _______________________________ **Date:** __________

**Please note: A separate Grant Service Receipt must be completed for each Service Provider**
THE ALS ASSOCIATION – Northern Ohio Chapter
The ALS Association Northern Ohio Chapter
Transportation Mileage Log
Mileage to and from ALS Clinic, ALS Doctor or Clinical Study Facility

*No other mileage is reimbursable*
Reimbursement is made based on .50 cents/mile

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason for Travel</th>
<th>Miles Traveled</th>
<th>$ Amount</th>
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<tbody>
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The ALS Association Northern Ohio Chapter
Transportation Mileage Log
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</tbody>
</table>

Page 5
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: alscaregrant@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 2022 Federal Poverty Guidelines can be found below.

<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>$13,590</td>
<td>$67,950</td>
</tr>
<tr>
<td>2</td>
<td>$18,310</td>
<td>$91,550</td>
</tr>
<tr>
<td>3</td>
<td>$23,030</td>
<td>$115,150</td>
</tr>
<tr>
<td>4</td>
<td>$27,750</td>
<td>$138,750</td>
</tr>
<tr>
<td>5</td>
<td>$32,470</td>
<td>$162,350</td>
</tr>
<tr>
<td>6</td>
<td>$37,190</td>
<td>$185,950</td>
</tr>
<tr>
<td>7</td>
<td>$41,910</td>
<td>$209,550</td>
</tr>
<tr>
<td>8</td>
<td>$46,630</td>
<td>$233,150</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $23,600 for each additional person to the 500% level column.

If you have any questions, please contact a care coordinator at 888/216-592-2572.
OPTIONAL FORM OF PAYMENT

PLEASE ONLY COMPLETE THIS FORM ONCE

I hereby authorize The ALS Association Northern Ohio Chapter to make ACH deposit entries on my behalf and pay that amount to:

Account Type: ☐ Checking   ☐ Savings

Name on Acct: ________________________________

Bank Name: ________________________________

Account Number: ________________________________

Bank Routing #: ________________________________

Bank City/State: ________________________________

I authorize The ALS Association Northern Ohio Chapter to initiate credit entries, and if necessary, to initiate any debit entries to correct an erroneous credit entry to my account at the financial institution listed above for the purpose of automatically depositing funds as indicated above.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The ALS Association Northern Ohio Chapter in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next payment date.

_____________________________________________
(Printed Name)

_____________________________________________
(Signature- REQUIRED)

_____________________________________________
(Date)

PLEASE ATTACH A VOIRED CHECK TO THIS FORM FOR VERIFICATION