ALS ASSOCIATION Northern Ohio Chapter

THE ALS ASSOCIATION – Northern Ohio Chapter

Grant Service Receipt ***(if no commercial billing statement from the vendor)***

Instructions: If service provider (driver, sitter, lawn care, snow plow, housekeeper, etc.) does not have their own billing receipt, please complete this Grant Service Receipt. Service Provider can be a company or individual. Please send this with your combined application for reimbursement along with any other appropriate receipts.

Client Name: ____

Signature:____ ***Date:***________________

Name if other than client : ____

Relation to the Client: ____

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

Name of Provider: ____

Address: _________________________ ***City/State:*** ___________________ ***Zip:***__________

Home Phone: _______________________________ ***Cell:*** ______________________________

Date of Service	Service Provided	Number of Hours	Hourly Rate	Total Paid

TOTAL $ _______________

Service Provider Signature:_____________________________ ***Date:*** _____________

***** Please note: A separate Grant Service Receipt must be completed for each Service Provider *****

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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

Date	Reason for Travel	Miles Traveled	$ Amount

TOTAL $ ________________________

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*Date Received in ALS Office*_______________________ **
VOD on File ______________ **

The ALS Association Northern Ohio Chapter

DME or ALS related products Expense Report Summary Page

Item Purchased	Where Purchased	Insurance Coverage? Y/N	$ Amount

Total $ _______________

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VOD on File ______________ **

OPTIONAL FORM OF PAYMENT

PLEASE ONLY COMPLETE THIS FORM ONCE

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

Account Type: ☐ Checking ☐ Savings

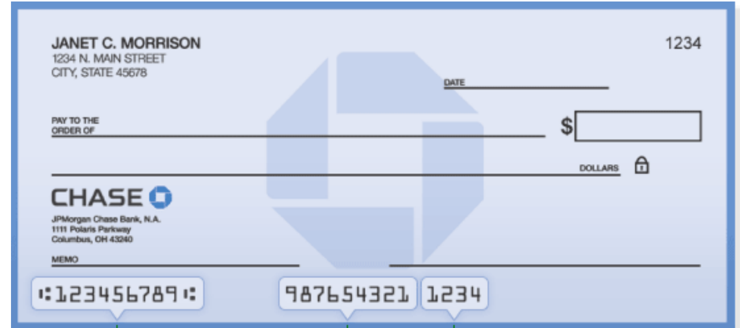
Name on Acct ______________________________

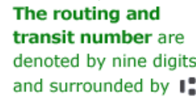
Bank Name ______________________________

Account Number ______________________________

Bank Routing # ______________________________

Bank City/State ______________________________





The checking account number

The check number

In some cases the order of the checking account number and the check number is reversed.

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 VOIDED CHECK TO THIS FORM FOR VERIFICATION IF AVAILABLE

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