



## **ALS Care Grant: Application Steps**

The ALS Association's ALS Care Grant will only reimburse for needs related to your ALS diagnosis that occur within the calendar year.

The Northern Ohio ALS Care Grant is funded through the Ohio Legislature and the American Rescue Plan Act. Therefore, recipients must be a resident of the state of Ohio. Only one grant is permitted per person with ALS/family and must not be combined with any other Ohio funds using the American Rescue Plan Act Funding. Questions? Call 216-592-2572

Funds are meant to assist with costs of living with ALS such as:

- Durable medical equipment and medical supplies
- Home modifications
- In-home and respite care
- Professional services (Examples: allied health providers; therapy and medical appointments)

The ALS Care Grant will provide a maximum benefit of \$ 2000.00 per client annually. Grants are provided based on availability of funds.

**RECIPIENTS MUST BE A RESIDENT IN THE STATE OF OHIO.**

**RECIPIENTS MUST BE REGISTERED WITH THE ALS ASSOCIATION AND RESIDE IN DESIGNATED COUNTIES.**

**RECIPIENTS MAY NOT COMBINE FUNDS WITH OTHER OHIO GRANTS USING FUNDING THROUGH THE AMERICAN RESCUE PLAN ACT.**

**Step 1:** Complete the application form- fill it out completely and sign it.

**Step 2:** Return the completed form to [midatlantic.caregrant@als.org](mailto:midatlantic.caregrant@als.org) or via US Mail at the office address listed on the application form. Please do not include any receipts for reimbursement with your application; however, you may be asked to show proof of expenses in case of an audit.

**Step 3:** Upon approval, you can anticipate payment in the mail in approximately 3 weeks. Please note that your payment will arrive in the mail and will not include the ALS Association name or logo; instead, the name bill.com will appear in the return address section of the envelope.

**Step 4:** You will receive an award letter and survey, please complete the survey after you receive your payment. This survey will assist us in assessing grant benefits and ensure future funding for the Grant Program.

The ALS Association

6133 Rockside Road, Suite 301

Independence, OH 44131

[www.als.org/northern-ohio](http://www.als.org/northern-ohio)

Phone: 216-592-2572

Fax: 216-592-2575

Mail to: The ALS Association  
6133 Rockside Road, Suite 301  
Independence, OH 44131

Email to: midatlantic.caregrant@als.org  
Fax to: 216-592-2575

Questions: Lisa Bruening  
216-867-1262  
Lisa.Bruening@als.org

### ALS Care Grant Application and Authorization Form

Client Name: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Client Address (not a PO Box) \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Do you attend an ALS Clinic? \_\_\_ Yes \_\_\_ No If yes, name/location of the clinic \_\_\_\_\_

Neurologist's Name: \_\_\_\_\_

Are you a Veteran? \_\_\_ Yes \_\_\_ No Mail check to client OR mail check to caregiver? \_\_\_ Client \_\_\_ Caregiver

Spouse/Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address if different from client: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Purpose (Refer to instruction sheet if more information required)	Place "X" or Check	Expected Cost	Amount Covered by Insurance Y/N	Brief Description
Respite: Hired Care				
Home Modification				
Medical Equipment				
Medication (FDA Approved)				
Vehicle Modification				
Speech Generating Device				
Access to ALS Clinic, ALS Physician/Allied Health Professional and/or Hospitalization				
Special Circumstances:	Please describe:			

**Policies and Procedures:** The ALS Association ALS Care Grant assists with the care and needs of those living with ALS. The ALS Association assumes no responsibility or liability for any direct or indirect services, products, or client care, or for the care arrangement and/or business relationship between the ALS client and their selected product or service provider. The ALS Association will issue an award letter for the ALS Care Grant. The ALS Association assumes no fiscal responsibility beyond the approved grant amount.

Applicants must sign and date this application, agree to the listed policies and procedures, and mail or email the completed application to the local office.

**To the best of my knowledge and belief, the information I provided on this application is true, correct, and complete. I have read the Quality-of-Life Grant Policies and Procedures and agree to abide by the requirements as noted.**

Applicant (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature/Relationship to client: \_\_\_\_\_

RECIPIENTS OF THIS GRANT MUST BE A RESIDENT IN THE STATE OF OHIO

<b>Office Use Only:</b>
Total Submitted _____ Amount Awarded _____ Approved by _____ Date _____
Region/Chapter: _____ Restricted ___ Yes ___ No Named Fund: _____
Notes for Accounts Payable Tracking: _____

## ALS Care Grant Program Guidelines

<b>ACCEPTABLE REIMBURSEMENTS</b>	<b>NOT COVERED</b>
<b>RESPIRE</b> <i>(after the maximum grant award from the Respite program has been used)</i>	<b>ALS CARE GRANT DOES NOT COVER</b>
<ul style="list-style-type: none"> <li>Companion and caregiver services by anyone <b>NOT</b> living in the home.</li> <li>In-home hired care; licensed, professional caregiving agency preferred.</li> <li>Lawn care and snow removal/housecleaning may not be provided by someone living in the home. <b>(requires pre-approval)</b></li> </ul> <p><i>Traditional respite requests are handled through the ALS Respite Program. Contact your care services coordinator for info.</i></p>	<ul style="list-style-type: none"> <li>Residential living - room and board fees.</li> <li>Caregiving, cleaning or lawncare, snow removal by those in same home.</li> </ul>
<b>COMMUNICATION (medically necessary, physician prescription required)</b>	<b>ALS CARE GRANT DOES NOT COVER</b>
<p>Coverage of technology or devices designed to be useful only to the person with ALS/PLS and would not be considered useful to others without ALS/PLS (smart home devices may be considered)</p> <ul style="list-style-type: none"> <li>Speech generating devices, which may include:</li> <li>Augmentative communication device <i>(limited to 1 device)</i>.</li> <li>Full Windows Tablet (limited to 1 device)/ iPad <i>(limited to 1 device)</i></li> <li>Text to Speech or communication software for above device.</li> </ul>	<ul style="list-style-type: none"> <li>Computer repairs.</li> <li>Internet fees or phone bills.</li> <li>Televisions/Apple TV, cable connection, email service fees.</li> <li>Virus protectors.</li> <li>Computer table/desk, iPad/tablet/computer accessories.</li> </ul>
<b>MEDICAL EXPENSES, EQUIPMENT &amp; SUPPLIES</b> <i>(medically necessary, physician prescription required)</i>	<b>ALS CARE GRANT DOES NOT COVER</b>
<ul style="list-style-type: none"> <li>FDA approved medications for the treatment of ALS, <ul style="list-style-type: none"> <li>i.e., Riluzole, Rilutek, Tiglutik, Nuedexta, Edaravone, Radicava, Relyvrio, Baclofen, Elavil, Amitriptyline, Elavil, Glycopyrrolate.</li> <li>ALS specific medication infusion supplies or charges</li> </ul> </li> <li>Diaphragm pacer co-payments &amp; supplies.</li> <li>Durable medical equipment, such as prescribed medical beds and mattresses, wheelchairs, transfer devices, lifts, bedside commodes, etc. Also includes respiratory and airway clearance devices.</li> <li>Medically necessary wheelchair upgrades, including cushions, seat lift elevators, adapted drive control mechanisms, attendant controls, etc.</li> <li>AFO braces/splints, neck braces, hand splints, adapted utensils.</li> <li>ALS Specialists, Clinic fees.</li> <li>PEG tube supplies/equipment and enteral nutritional formulas administered through PEG. (May also include medically recommended nutritional formula taken by mouth)</li> <li>Portable ramps (portable ramps are 6-10 feet in length), generators.</li> </ul>	<ul style="list-style-type: none"> <li>Over the counter or prescription medications not related to ALS/PLS.</li> <li>Health insurance premiums.</li> <li>Any type: clothing, groceries, toiletries, shoes, sheets, blankets, pillows.</li> <li>Utility bills (including home security alarm systems).</li> <li>Non-ALS related doctor/hospital fees or co-payments (includes vision &amp; dental).</li> <li>Acupuncture/massages/massage therapy/ massage cushions/hand massagers.</li> <li>Pool fees or equipment, exercise equipment.</li> </ul>
<b>HOME MODIFICATIONS (medically necessary, physician prescription required)</b>	<b>ALS CARE GRANT DOES NOT COVER</b>
<ul style="list-style-type: none"> <li>Construction/installation of ramps, wheelchair platforms lift, stairlifts.</li> <li>Bathroom accessibility.</li> <li>Doorway accessibility.</li> </ul>	<ul style="list-style-type: none"> <li>Home maintenance/repairs (including driveway and sidewalk repairs).</li> <li>Interior or exterior painting.</li> </ul>
<b>TRANSPORTATION (ALS or PLS MEDICAL USE ONLY)</b>	<b>ALS Care grant DOES NOT COVER</b>
<ul style="list-style-type: none"> <li>Mileage to and from ALS Team Clinic, FDA approved clinical study, ALS related medical appointments, such as pulmonary, gastroenterology, diaphragm pacer &amp; vent procedures.</li> <li>Rental of vehicle and/or car service to get to/from ALS-related medical appointments, ALS Team Clinic, clinical study.</li> <li>Adaptations for vehicles to make them accessible.</li> <li>Lodging for ALS Team Clinic appointments. Limits: 1 room, 2 nights; does <b>NOT</b> include meals)</li> </ul>	<ul style="list-style-type: none"> <li>Mileage to and from pharmacy, dental, vision or any medical appointments not listed on left.</li> <li>Purchase of any automobiles (including accessible van).</li> <li>Automobile maintenance, including, but not limited to tire replacement, oil change, body, or engine repairs.</li> </ul>