ALS ASSOCIATION – ALABAMA CHAPTER
300 CAHABA PARK CIRCLE, SUITE 209 BIRMINGHAM, AL 35242
TEL: 800-664-1242 INFO@ALSALABAMA.ORG

APPLICATION FOR CARE SERVICES GRANT PROGRAM

TODAY'S DATE:_____ APPLICANT NAME (PERSON WITH ALS)_____
Primary Caregiver Name: _____

Insurance: Check all that apply) □ Private Insurance, what type_____ □ Medicare (Part B) □ Medicaid
□ Veterans Benefits □ Yes □ No

Phone (Home) _____ Cell _____ Work_____

Address: _____

Email: _____

Number of persons living in household? ____ How many children? _0_____

Program you are applying for: (**Answer questions only related to the program you are applying for**)

- Accessibility Grant – (receipts required)
- ADL Grant
- Communication Grant
- Transportation Grant

Briefly describe the need you have related only to the grant you are applying for:_____
_____
_____
_____
_____

- Are you financially able to meet your monthly expenses? Circle YES or NO

FOR CHAPTER USE ONLY

All required paperwork completed ___ Yes ___ No

Prioritization #: _____ Approved: _____Yes ____No

Patient Service Coordinators: _____Date: _____

Needs referral to Patient Service Committee ____ Yes ____ No