

*ALS Recovery Foundation  
Patient Care Fund  
Grant Request*

We thank you for your interest in the ALS Recovery Foundation's Patient Care Fund. The Foundation seeks to aid families impacted by ALS by providing financial assistance to those in need of equipment and/or supplies. To better help us, help you, please answer the following questions and attach copies of those requested documents.

The ALS Recovery Foundation is a 501 (c)(3) non-profit organization built on volunteers. The Foundation is committed to creating public awareness, promoting research and education, and raising funds in order to find a cure for this life-threatening disease.

The Foundation is pleased to be able to help those PALS in need of assistance. The Patient Care Fund is available to all residents of Dade, Broward, Monroe and Palm Beach County. If you have any questions regarding the application, please contact Ginna Gonzalez, R.N. Ms. Gonzalez can be reached via the following methods:

Tel: (305) 243-7400 or (800) 690-ALS1

Fax: (305) 243-1249

Email: [gina@waltek.net](mailto:gina@waltek.net)

Completed applications should be sent to:

The ALS Recovery Foundation Patient Care Fund  
C/o Kessenich Family MDA ALS Center  
1150 NW 14<sup>th</sup> Street, Suite 700  
Miami, FL 33136

# ALS Recovery Foundation Patient Care Fund Grant Request

The following Patient Care Grant Request should be completed and returned to the University of Miami Kessenich Family MDA ALS Center by fax [(305) 243-1249] or mail [The ALS Recovery Foundation Patient Care Fund, c/o Kessenich Family MDA ALS Center, 1150 NW 14<sup>th</sup> Street, Suite 700, Miami, FL 33136] along with the required documentation:

- Applicant must enclose a copy of their most recent tax return. If the Applicant is not required to file a tax return, enclose a letter from the IRS confirming such. The IRS can be reached at 1-800-829-1040;
- Applicant must file for an Explanation of Benefit (EOB) with its insurance company; and
- Applicant must provide a written estimate for the cost of such equipment.

Each request for assistance requires the Applicant to file a separate Grant Request and submit a copy of its most recent tax return.

**PATIENT**

Name (last, first) \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_, Florida Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Spouses Name \_\_\_\_\_ Number of Children and Ages \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Responsible Family Member \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_, Florida Zip \_\_\_\_\_

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**FINANCIAL INFORMATION**

Monthly Income (Total Amount) \_\_\_\_\_

Partner / Spouse Salary \$ \_\_\_\_\_ Soc. Sec. \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_

Short Term Disability \$ \_\_\_\_\_ Long Term Disability \$ \_\_\_\_\_

Veterans Benefits \$ \_\_\_\_\_ Other Income \$ \_\_\_\_\_

Please explain in detail the type of services/equipment you are requesting. (Feel free to attach additional pages)

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Please explain why you need the requested services/equipment. A professional referral must be enclosed.

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Please explain in detail why health insurance is not a viable option towards acquiring the requested services/equipment. (Feel free to attach additional pages)

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Have you sought financial assistance for the services requested above from any other sources? Yes/No \_\_\_\_\_

If yes, from whom? \_\_\_\_\_

When was the request made? \_\_\_\_\_

What was the result? \_\_\_\_\_

Are there any other relevant circumstances we should be made aware of? \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY**

Service Requested: \_\_\_\_\_

Service Approved: Yes \_\_\_ No \_\_\_

Amount Approved: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_