ALS Recovery Fund
Patient Care Fund
Grant Request

We thank you for your interest in the ALS Recovery Fund's Patient Care Fund. The Fund 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 Fund is a 501 (c)(3) non-profit organization built on volunteers. The organization is committed to creating public awareness, promoting research and education, and raising funds for patient care and research in order to find a cure for this life-threatening disease.

The ALS Recovery Fund 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: GGonzal4@med.miami.edu

Completed applications should be sent to:

The ALS Recovery Fund Patient Care Fund
C/o Kessenich Family MDA ALS Center
1120 NW 14th Street, Suite 1311
Miami, FL 33136

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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 Fund Patient Care Fund, c/o Kessenich Family MDA ALS Center, 1129 NW 14th Street, Suite 1311, Miami, FL 33136] along with the required documentation:

- Applicants 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;
- Applicants must file for an Explanation of Benefit (EOB) with their insurance company; and
- Applicants 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 his or her most recent tax return.

PATIENT

Name (last, first) _____ Today's Date _____

Home Address _____ Phone _____

City _____, Florida Zip _____

Age _____ Date of Diagnosis _____

Spouse's 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)

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

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? _____
_____
_____
_____
_____
_____
_____
_____

FOR OFFICE USE ONLY

Service Requested: _____
Service Approved: Yes ___ No ___
Amount Approved: _____
Authorized Signature: _____
Date: _____