



The ALS Association - Jim "Catfish" Hunter Chapter

Flex Grant Program Application Form

****PLEASE DO NOT SEND RECEIPTS UNTIL THIS APPLICATION IS APPROVED. THANK YOU.**

Grant Information

- Flex Grants are available monthly and are awarded based on need and available funding.
- To be considered, the grant application must be in our office by midnight of the 25th day of each month. Late applications will be considered for the next month.
- The application must be filled out in full to be considered.
- Each grant is for \$500.00.
- A recipient can request two grant per fiscal year running from February 1st to January 31st.
- A billing receipt must be submitted with attached receipts to receive reimbursement.
- Grants are intended to provide help for families living with ALS.
- Receipts from grantee or vendor acceptable.
- Grant Uses*
 - Home Modification
 - Durable medical equipment
 - Generators
 - Track lifts
 - Auto Modifications
 - Wheelchair modifications/repairs

* This list may not be all inclusive. Check with the Chapter if you have questions.

For questions or more information about the Flex Grant Program, please contact Katie Liles toll free at 1-877-568-4347 or katie@CatfishChapter.org.



**Jim "Catfish" Hunter
Chapter**

The ALS Association
Jim "Catfish" Hunter Chapter
120-101 Penmarc Drive
Raleigh, NC 27603

Flex Grant Program Application

I. Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of birth: _____

E-mail address: _____

Do you attend an ALS Clinic? Yes___ No___ If yes, please provide Clinic
& Neurologist name _____

Date of Diagnosis: _____

II. Caregiver Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of birth: _____

E-mail address: _____

Relationship to Patient: _____

III. Please check levels of ability and disability

	<u>Total Care/Assist</u>	<u>With Assistance</u>	<u>No Help Needed</u>
Upper Body Limbs	_____	_____	_____
Lower Body Limbs	_____	_____	_____
Speech	_____ (Unable to speak)	_____ (Speech affected)	_____ (Speech unaffected)
Eating/Swallowing	_____	_____	_____
Breathing	_____ (Ventilator)	_____ (Bi-Pap)	_____
Bathing	_____	_____	_____
Toileting	_____	_____	_____
Medications	_____	_____	_____
Repositioning	_____	_____	_____

Other information on patients' condition:

IV. Household Income

(List **all** monthly sources including patient and others): Monthly Total \$ _____

1. _____
2. _____
3. _____
4. _____
5. _____

V. Number of Dependants on Income

Please list number of dependants on indicated income by age and relationship.

	<u>Name</u>	<u>Age</u>	<u>Relationship to Patient</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

VI. Additional Information

Will insurance cover some of all of the cost of the item needed?

- Yes
- No
- I don't know (If unsure, check with your physician or therapist.)

If yes, what is your co-payment? _____

Other resources you can consider in addition to this grant opportunity:

MDA, Churches, Family and Friends, Care Connection Team

Will MDA or other resources cover some or all of the cost of this need?

- Yes
- No
- I don't know (If unsure, check with your physician or therapist.)

If yes, how much is covered? _____ How much is not covered? _____

What type of device/service do you need? _____

How will this device/service assist you?

- ___ Ability
 - ___ Quality of Life
 - ___ Communication
 - ___ Mobility
 - ___ Access to Services
 - ___ Improve Caregiver Support
 - ___ Other - Please explain: _____
-

Indicate how often this device/service would be used:

- ___ Daily
- ___ Weekly
- ___ Monthly
- ___ One-time use

Additional comments or extenuating circumstances:

Are you currently using the Care Connection caregiving program?

- Yes
 No

If no, would you like to learn more about this program?

Care Connection: This helping approach has aided many ALS families and community caregivers as they deliver quality supportive care. The ALS Association can offer the family and those who want to help a blueprint for providing a family with support that is tailored to their specific needs.

Please review grant policies and procedures below:

POLICIES AND PROCEDURES*

The Jim “Catfish” Hunter Chapter Flex Grant Program assists with the needs of those families living with ALS within the Chapter’s service area.

Grants will be awarded in the amount of \$500.00 or for no more than the amount approved. Receipts and a billing statement must be submitted for reimbursement. The Chapter will maintain a balance in the case that all funds are not immediately utilized. Individuals may apply and receive up to two grants per year.

After receiving a grant from this program, applicants cannot reapply until the following fiscal year.

Grants will be awarded each month based on the number of applications received and available funds. Applications will be selected based on need and prior selection status. The Chapter’s Patient Services Committee will score all applications to determine the grant recipients each month. Applications that are not chosen will be considered the following month. If applicant is denied a second time, a new application must be re-submitted to be considered for the grant again.

Eligibility

- The patient must have a definitive diagnosis of ALS and reside in the Chapter’s service area.
- The applicant must establish need for Chapter assistance.
- Applicant must **sign and date this application and agree to the Policies and Procedures** and mail or fax to the Chapter office.

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120-101 Penmarc Drive
Raleigh, NC 27603
Toll Free: 1(877) 568-4347
Phone: (919) 755-9001
Fax: (919) 755-0910

Applications must be received on or before the 25th day of the month to be considered for a grant for the following month. Grant selections will be made between the 25th day and the last day of each month. Grant applicants will be notified in writing. After the grant is confirmed, grant recipients may choose to receive direct reimbursement** for expenses by supplying a signed billing receipt (provided by Chapter) or they may arrange for direct billing/invoice to the Chapter from the service provider. The grant must be used within 1 year after the grant has been awarded.

To the best of my knowledge and belief, the information I provided above is true, correct, and complete. I have read the Flex Grant Program Policies and Procedures and agree to abide by the requirements as noted.

Applicant (Print)

Date

Signature

Relationship to Patient

ALSA-JCH Staff/Representative

Date Application Received

*Policies and Procedures are subject to change.

** You may be responsible for paying taxes on grant monies received. Please consult your tax professional or the IRS for more information.