

THE ALS ASSOCIATION - Jim "Catfish" Hunter Chapter
Grant Service Receipt (only if needed)

Instructions: If Service Provider (driver, sitter, etc.) does not have their own billing receipt, please have them fill out a Grant Service Receipt. Service Provider can be a company or individual. Please attach the receipt to Billing Statement for Reimbursement along with any other appropriate receipts.

Patient Name: _____

Grant Type (circle one): **Respite** **Transportation** **Flex** **Assistive Technology**

Service Provider Information

Name : _____ **Date:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: _____ **Other:** _____

Service Provided/Equipment Purchased (For Transportation Grant only, please include destination, mileage, etc.):_

Billed Amount: \$ _____ (If hourly: \$ _____ per hour x number of hours: _____)

Service Provider Signature: _____ **Date:** _____

Patient/Caregiver Signature: _____ **Date:** _____

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