

The ALS Association - Jim "Catfish" Hunter Chapter

Respite Care Grant Program Billing Statement for Reimbursement

Patient Information

Name: _____ Today's Date: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of person completing this form: _____

Relationship to Patient: _____ Phone (if different): _____

Date(s) respite care was provided: _____

Total # hours of care for dates noted above: _____ Hourly rate: \$ _____

Please fill out the appropriate box(s) below:

Reimbursement Information (To be paid directly to the grantee)

Name of individual to be reimbursed: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ *Social Security #: _____

Amount: \$ _____ (Attach all receipts/proof of payment to this statement)

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

- AND/OR -

Direct Billing Information (Please complete if there is a bill to be paid directly to service provider)

Company/Individual Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ *Social Security/EIN #: _____

Amount: \$ _____ (Attach appropriate invoice/bill to this statement)

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

Please note that it may take a few weeks to receive a reimbursement check after sending this completed statement. If you do not receive a check from us within two weeks of sending this statement, you may call us toll free at (877) 568-4347 to inquire about the status of your reimbursement.

Today's Date: _____ Signature: _____

**Please fax or mail this completed billing statement
along with copies of appropriate receipts to:**

ALSA- Jim "Catfish" Hunter Chapter
Attn: Respite Care Program
120-101 Penmarc Drive
Raleigh, NC 27603