

## **THE ALS ASSOCIATION – WISCONSIN CHAPTER TRANSPORTATION / FLEX GRANT PROGRAM**

The Wisconsin Chapter Grant Program assists with the needs of those families living with ALS.

The applicant must have a definitive or probable diagnosis of ALS.

The applicant must register with the Wisconsin Chapter and reside in the Chapter service area or is receiving care through the ALSA Certified Clinic at Froedtert Hospital/MCW.

Grants will be awarded monthly and are based on available funds. First-time applicants may be given priority.

Grant amounts vary depending upon type:

Transportation Grant = \$250 (may apply for and receive four grants per year)

Flex Grant = \$500 (may apply for and receive two grants per year)

### **Possible Grant Uses\***

#### **Transportation**

Travel costs incurred due to ALS:  
Ex: gas / transport service / van rental;  
one night lodging related to  
medical clinic appointment  
or a Chapter event (ex: symposium,  
support group)

#### **Flex**

Home / Auto / Van Modifications  
Medical Equipment / Adaptive devices  
not covered by medical insurance;  
Generators / Wheelchair Batteries;  
Communication device accessories

**\* This list is not all inclusive and is subject to change. Check with the WI Chapter Patient Services Director if you have any questions or need more information:  
Lori Banker-Horner at 414.817.1541 or [lori@alsawi.org](mailto:lori@alsawi.org).**

To be considered, the Grant Application must be received in our Chapter Office by midnight of the 20<sup>th</sup> day of each month. Late applications will be considered for the next month.

ALS Association WI Chapter Office  
Attn: Lori Banker-Horner  
2505 North 124<sup>th</sup> Street, Suite 105  
Brookfield, WI 53005

**PHYSICIAN FORM**  
**Verification of ALS Diagnosis**

(This page should only be completed the first time you apply for a grant.)

**To be completed by Patient / Caregiver**

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Contact person \_\_\_\_\_  
Name Phone Number

**To be signed by Neurologist specializing in ALS**

By my signature, I verify that I have diagnosed the above named individual with Amyotrophic Lateral Sclerosis (ALS) or Probable/Possible ALS. This diagnostic designation affords this individual access to all of the programs and services available through the ALS Association Wisconsin Chapter.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone

# Grant Application

**Circle ONE choice only:**      **FLEX**                      **TRANSPORTATION**

## **I. Recipient Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email Address \_\_\_\_\_

ALS Clinic Name \_\_\_\_\_ Neurologist Name \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Date of birth \_\_\_\_\_

Veteran?    \_\_\_ Yes    \_\_\_ No    If yes, Branch and Dates of Service: \_\_\_\_\_

Registered with VA?    \_\_\_ Yes    \_\_\_ No

## **II. Family Member or Primary Caregiver Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email 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	___ Speech (unable to speak)	___ (Speech affected)	___ (Speech unaffected)
Eating / Swallowing	___	___	___
Breathing	___ (Ventilator)	___ (Bi-Pap)	___
Bathing	___	___	___
Toileting	___	___	___
Medications	___	___	___
Repositioning	___	___	___

Other information on patients' condition (continue on back side of this page if needed)

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

**GRANT APPLICATION, continued**

**VI. Additional Information**

If applying for **Transportation Grant**, please answer the following:

Do you have free access (excluding gas) to an appropriate vehicle that meets your current transportation needs?

\_\_\_\_\_ YES    \_\_\_\_\_ NO    If no, do you need to rent a: VAN \_\_\_\_\_ or a CAR \_\_\_\_\_

Available Driver Information:

Lodging (over night stay)

\_\_\_\_\_ I have a driver that can drive me at no charge.

\_\_\_\_\_ Attend clinic / medical appointment

\_\_\_\_\_ I must hire a driver

\_\_\_\_\_ Chapter event

Comments: (If for overnight lodging needs, please include type of medical appointment & date or Chapter event & date.)

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If applying for the **Flex Grant**, please provide the following information:

What type of device / service / home / auto modification(s) do you need? \_\_\_\_\_

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How will this device / service / home / auto modification(s) assist you? (Please check all that apply.)

Improve Independence \_\_\_\_\_

Improve Quality of Life \_\_\_\_\_

Improve Mobility \_\_\_\_\_

Additional comments or extenuating circumstances (continue on back side if more space needed): \_\_\_\_\_

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**THE ALS ASSOCIATION – WISCONSIN CHAPTER  
TRANSPORTATION / FLEX GRANT PROGRAM  
POLICIES AND PROCEDURES\***

The applicant must have a definitive or probable diagnosis of ALS. The applicant must register with the Wisconsin Chapter and reside in the Chapter service area or is receiving care through the ALSA Certified Clinic at Froedtert Hospital/MCW.

The Grant Application must be filled out in full to be considered.

First-time applicants must complete the Physician Form **including** Physician's signature.

Applications must be received on or before midnight of the 20<sup>th</sup> day of the month to be considered for a grant for the following month. Grant selections will be made between the 21<sup>st</sup> day and the last day of each month. Applicants will be notified of grant awards during the first week of the following month. **After** the grant is confirmed, grant recipients will receive direct reimbursement\*\* for expenses after submitting receipts / proof of payment with the signed Billing Statement for Reimbursement form.

After receiving one grant from this program, applicants must reapply to be considered for subsequent grants. Please do not reapply for another grant (of the same type, i.e. Flex or Transportation) until you have submitted receipts for the previous approved grant and have utilized the entire grant award.

**Grants must be used within six months after the Grant has been awarded.**

Applicants must sign and date this application and agree to the Policies and Procedures.

Mail the application to:   The ALS Association – Wisconsin Chapter  
                                  Attn: Lori Banker-Horner  
                                  2505 North 124<sup>th</sup> Street, Suite 105  
                                  Brookfield, WI 53005

Direct contact: Phone: 414.817.1541 or [lori@alsawi.org](mailto:lori@alsawi.org)

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

\_\_\_\_\_  
Applicant (Print Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient  
(if patient unable to sign form)

\_\_\_\_\_  
ALSA-WI Staff / Representative

\_\_\_\_\_  
Date Application Received

\* Policies and Procedures are subject to change.

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