ALS Northern Ohio Chapter ASSOCIATION

*Date Received in Office* _____
*Review Required: Yes*_____ *No*_____

ALS Care Grant Program

**Billing Statement for Reimbursement**

**Payee Designation (if other than patient) -- Reimbursement can only be made to the person listed below.**

**Patient Name:** _____**Today's Date:** _____

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

**Phone:** _____**Email:**_____

**Payee (if other than patient):** _____**Relationship to Patient:**_____

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

| | |
|---|---|
| **FOR SERVICES BEING PROVIDED** | **Complete a GRANT SERVICE RECEIPT (if receipt is not provided to you by service provider) and attach to this completed form.** |
| **FOR TRANSPORTATION EXPENSES** | **Complete a MILEAGE LOG FORM and attach to this completed form, (we cannot accept gas receipts).** |
| **FOR PURCHASED ITEMS** | **Attach copy of actual invoice/receipts to this completed form (We cannot accept credit card statements, bank statements or copies of checks).** |

| Quarter | Acceptable Date Range for Receipts | Receipts Due By: |
|---|---|---|
| **1st** | October 21 – April 20 | April 20 |
| **2nd** | January 21 – July 20 | July 20 |
| **3rd** | April 21 – October 20 | October 20 |
| **4th** | July 21 – January 20 | January 20 |

**FOR ALSA USE ONLY**

Amount: _____

Approved By: _____

Date: _____

**Please note that it may take up to three weeks to receive a reimbursement check after sending this completed statement**. If you do not receive a check from us within three weeks after sending this statement, you may contact Cathy at 216-592-2572/888-592-2572 or email alscaregrant@alsaohio.org to inquire about the status of your reimbursement.

***PLEASE REVIEW REIMBURSEMENT GUIDELINES AND ACCEPTABLE DATE RANGES BEFORE SUBMITTING***

***By signing this form, I am agreeing to honor the date and reimbursement guidelines listed above.***

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

**Please send THIS completed Billing Statement form WITH appropriate paperwork as listed above to:**

**The ALS Association Northern Ohio Chapter**
**6155 Rockside Road, Suite 403**
**Independence, OH 44131**
Phone: 216-592-2572/888-592-2572
Fax: 216-592-2575
Email: alscaregrant@alsaohio.org

ALS Northern Ohio Chapter ASSOCIATION

***THE ALS ASSOCIATION – Northern Ohio Chapter***
***Grant Service Receipt (only if needed)***

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

***Patient Name:*** _____

***Patient/POA Signature:*** _____ ***Date:*** _____

***Service Provider Information (MUST BE COMPLETED/SIGNED BY SERVICE PROVIDER)***

***Name of Provider:*** _____

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

***Home Phone:*** _____ ***Cell:*** _____

| Date of Service | Service Provided | Number of Hours | Hourly Rate | Total Paid |
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***Service Provider Signature:*** _____ ***Date:*** _____

***** Please note: A separate Grant Service Receipt must be completed for each Service Provider *****

The ALS Association Northern Ohio Chapter
Transportation Mileage Log
Mileage to and from ALS Clinic, ALS Doctor or Clinical Study Facility
**No other mileage is reimbursable**
Reimbursement is made based on .50 cents/mile

| Date | Reason for Travel | Miles Traveled | $ Amount |
|---|---|---|---|
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