Quality of Life Reimbursement Grant Program
Reimbursement Request Form

This form Must be Completed & sent in with eligible receipts for EACH Reimbursement Request

ALS Association Central & Southern Ohio Chapter

RECEIPTS OR INVOICES CLEARLY INDICATING ITEM(S), OR SERVICE(S) PAID ARE REQUIRED FOR REIMBURSEMENT

Patient Information – Payment will only be made to patient

Patient Name: _____Today's Date: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Product/Service: _____Reimbursement Amount Requesting: _____

By signing this form, I am agreeing to honor the date and reimbursement standards listed below.

Signature: _____ Date: _____

(patient/person completing this form – typed name on PDF is acceptable)

STANDARDS FOR RECEIPTS TO BE INCLUDED WITH THIS COMPLETED REQUEST FORM

FOR **SERVICES** BEING PROVIDED	**IF receipt is not** provided to you by your service provider, **THE PROVIDER MUST** complete a "**Service Provider Receipt**" it must be attached to **THIS** completed "**Reimbursement Request Form**."
FOR **TRANSPORTATION** EXPENSES	If submitting for mileage, you **MUST** complete a "Mileage Log" & attach to **THIS** completed "**Reimbursement Request Form**" Gas receipts not accepted.
FOR **ITEMS PURCHASED**	Attach **COPIES OF ACTUAL RECEIPTS, OR INVOICES indicating payments have been made NEED to be attached** to **THIS** completed "**Reimbursement Request Form**" (**NOTE: We CANNOT accept credit card statements, bank statements, or copies of cancelled checks)**

- Forms and receipts must be received (postmarked) **by Monday- January 15th, 2024**
- Your receipts can be dated **no earlier than January 5th, 2023**
- Please carefully review the "**Grant Guidelines**" provided to be sure your expenses for reimbursement are acceptable.

FUNDS ARE EXTREMELY LIMITED AND WILL BE GIVEN OUT ON A FIRST COME, FIRST SERVE BASIS UNTIL FUNDS ARE EXHAUSTED!

FOR CHAPTER USE ONLY

Amount:

Approved By:

Date:

If you have not received a check within **six (6) weeks of submitting this form, you may contact Care Services toll free at (866) 273-2572 to inquire about the status of your reimbursement.

Please fax, mail, or email this completed Reimbursement Request form WITH appropriate documentation, As stated above to:

The ALS Association Central & Southern Ohio Chapter
1170 Old Henderson Rd. -- Suite 221
Columbus, OH 43220
FAX: (614) 273-2573 or email – chubbell@alsohio.org