ALS Central & Southern Ohio Chapter ASSOCIATION

Quality of Life Reimbursement Grant Program
Service Provider Receipt

- **MUST** be sent in with a completed "**Reimbursement Request Form**."
- **Use ONLY if Service Provider DOES NOT** have his own receipt/invoice.
- Care Provider **CAN NOT** live in the same residence as person with ALS.

DATE	# OF HOURS	TYPE OF CARE PROVIDED

Total # Hours _____ x hour rate $ _____ = Total Amount Paid for Service: $ _____

By signing below, I acknowledge that the above information is true, correct, and complete.

Person with ALS Name (Print): _____

Signature: _____

Signature (Care Provider): _____

Date: _____