

Quality of Life Reimbursement Grant Program

Reimbursement Request Form

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



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