



Quality of Life Reimbursement Grant SERVICE PROVIDER RECEIPT

- **MUST** be sent in with a completed “**Reimbursement Request Form.**”
- Use **ONLY** if Service Provider **DOES NOT** offer a receipt/invoice.
- Care provider CANNOT 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: _____