2025 Quality of Life Reimbursement Grant
REIMBURSEMENT REQUEST FORM

This form MUST be completed & submitted 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: _____ Date of Birth: _____

Address: _____ City: _____ County _____ State/ Zip:_____

Phone: _____ Email:_____

Care Service Coordinator _____ 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**" and 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**	**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 canceled checks).**

- Forms and receipts must be received (postmarked) **by Monday- January 12, 2026**
- Your receipts can be dated **no earlier than January 21, 2025**
- **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 OFFICE 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:

ALS United Ohio
1170 Old Henderson Road, Suite 221
Columbus, OH 43220
FAX: (614) 273-2573 or email –LBridges@alsohio.org

Quality of Life Reimbursement Grant
2025 Reimbursement Guidelines

The Quality of Life Reimbursement Grant assists families with expenses that are not typically covered by private insurance, Medicare, Medicaid and other assistance programs. This grant will cover, but is not limited to, durable medical equipment, home care assistance, travel costs related to an ALS diagnosis or research, home or auto modifications, computer access, communication devices, smart home technology, environmental controls, and generators. Recipients may be reimbursed for up to $1,200 for approved expenses incurred from **January 21, 2025 to January 12, 2026.**

- Funding is limited and grants will be awarded on a first come first serve basis.
- Copies of RECEIPTS OR INVOICES clearly indicating payment(s) is necessary to receive reimbursement.
- Individuals do not have to wait to reach the $1,200 grant limit to submit expenses. You may submit expenses of $500 or more at a time. A submission of less than $500 will NOT be processed unless it the ONLY reimbursement request from the pALS.
- A Reimbursement Request Form is ALWAYS required.

Respite Care	
ACCEPTABLE REIMBURSEMENTS	**UNACCEPTABLE REIMBURSEMENTS**
• Patient sitting services by anyone NOT living in the home. • House cleaning, lawn/yard, or snow removal services **Must be performed at patient's primary residence.**	• Residential living - room and board fees. • Caregiving provided by anyone living in the home.
Communication Needs (medically necessary)	
ACCEPTABLE REIMBURSEMENTS	**UNACCEPTABLE REIMBURSEMENTS**
Communication devices, which may include: • iPad or similar tablet, Internet connected watch • Augmentative communication devices • Smart home & Augmentative communication accessories, software, and apps.	• Computer repairs. • Internet fees or phone bills. • Virus protectors.
Home Modifications (medically necessary)	
ACCEPTABLE REIMBURSEMENTS	**UNACCEPTABLE REIMBURSEMENTS**
Material and labor for the following - • Building of ramps or installation of lifts • Bathroom accessibility • General Home accessibility • Smart home technology	• Interior or exterior painting.

Reimbursement Guidelines

Medical Expenses, Equipment & Supplies (medically necessary)

ACCEPTABLE REIMBURSEMENTS	UNACCEPTABLE REIMBURSEMENTS
Copays, Fees, Costs for the following • FDA approved medication for treating ALS and symptoms • Medical Marijuana • Medical Marijuana Card • CBD products • Durable medical equipment. • ALS Clinic fees • PEG tube supplies • Bipap supplies • Wheelchair upgrades & repairs • AFO braces/splints • Beds and mattresses • Generators • Personal Alert Systems including smart watches • Portable ramps • Patient focused counseling prescribed by a neurologist or general practitioner. • Health Insurance Premiums • Alternative therapies prescribed by a neurologist or general practitioner. • Toiletries that help with treatment of ALS.	• Any over the counter or prescription medications (with the exception of medications prescribed by a medical professional to treat symptoms of ALS) • Utility bills • Non-ALS related doctor/hospital fees or co-payments (includes vision & dental).

TRANSPORTATION

ACCEPTABLE REIMBURSEMENTS	UNACCEPTABLE REIMBURSEMENTS
• Mileage to and from **ALS Clinics,** clinical study, ALS standard medical appointments such as - pulmonary, gastroenterology, physical, occupational & respiratory therapy, and vent procedures. • Rental of handicap accessible vehicle and/or car service. • Adaptations for vehicles to make them accessible. • Purchase of handicap accessible vehicle and/or maintenance of this vehicle. • Lodging for **ALS Clinic** appointments. • (1 room, 2 night limit; does **NOT** include meals) • Driving Evaluation	• Mileage to and from pharmacy, dental, vision or any medical appointments not listed on left. • Purchase of an automobile that is **NOT** handicap accessible.

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Quality of Life Reimbursement Grant

STORE RECEIPT LOG

- **If sending more than 2 receipts, please use this form.**
- This form **MUST** be sent in with a completed **"Reimbursement Request Form."** Please do not mail original store receipts. **Copies of RECEIPTS must be included with this form.**

PURCHASE DATE	ITEM DESCRIPTION	STORE NAME	ITEM COST
		TOTAL	

Quality of Life Reimbursement Grant
MILEAGE REIMBURSEMENT FORM

- Use **ONLY** if needed for mileage expenses to and from ALS Clinic, clinical study, or ALS standard medical appointments such as PT, OT, pulmonary, gastroenterology, and vent procedures**. NO OTHER MILEAGE IS REIMBURSABLE.**
- This form **MUST** be sent in with a **completed** "**Reimbursement Request Form.**"
- Gas receipts are **NOT** needed or acceptable.
- Reimbursement is made based on 67cents per mile.

DATE OF TRAVEL	ADDRESS FROM/ADDRESS TO	MILES TRAVELED	REASON FOR TRAVEL	$ AMOUNT
			TOTAL:	

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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:_____