APPLICATION

Please note: a separate application is needed for each individual transportation request

Name: ____

Street Address: ____

City, State, Zip: ____

Phone: ____________________ Email: ____________________

Caregiver Name/Relationship: ____________________ Phone: ____________________

VAN RENTAL REQUEST:

☐ **Van Rental:**

- Indicate number of days for rental ______________________________
- Dates for rental ______________________________
- Purpose of rental request ______________________________

DOOR-TO-DOOR NON-EMERGENCY TRANSPORT REQUEST – CHOOSE ONE:

☐ **ALS Clinic, Doctor's Appointment**

☐ **Social Activities (ex. Chapter Event, Church, Party Events, Movies, Shopping, Outing)**

- Pick Up Location: Street Address, City, State, Zip Code and Phone Number:

  ____

- Appointment Date/Time: ______________________________
- Drop Off Location: Street Address, City, State, Zip Code and Phone Number:

  ____

Please Indicate Type of Accommodation Currently Used:

☐ Power Wheelchair ☐ Able to ambulate, routine transport

☐ Transport Chair/Manual Wheelchair ☐ Stretcher

Financial Assistance Request - Vehicle Adaptions or Van Voucher:
(check appropriate box and include a written statement)

☐ **Van/Car Adaptations** ☐ **Van Voucher**

GUIDELINES

- **Transportation request must be submitted** at ***least 2 (two) weeks in advance*** of appointment.
- pALS must be accompanied by a caregiver.
- **Cancellations must be received 48 hours prior to scheduled pick-up** or pALS may incur a cancellation fee (*cancellation fee to be disclosed at time of scheduling*).
- If the appointment is cancelled by the medical provider, pALS must provide documentation of such to eliminate cancellation fee responsibility.
- **pALS are prohibited from arranging** transportation without approval of program coordinator under this program. (Authorization code will be given at the time of approval)
- Each transport requires pre-approval and a unique Authorization code.
- Utilizing the van rental option, all pALS/cALS must adhere to the legal ramifications governing van rentals in the state of Georgia as well as honor stipulations set forth by the van company.

By agreement with the ALS Association of Georgia, Inc., I understand that if approved for The Paul Williams ALS Transportation Program, services will be provided by a third-party transportation provider. I authorize the Program Coordinator to release and obtain any information necessary to complete this referral.

By signing below, I also acknowledge that the ALS Association of Georgia, Inc., is not a provider of medical or transportation services, and is only arranging for transportation services by a third-party provider. The ALS Association of Georgia, Inc. will not be providing medical or transportation services of any kind. As such, by signing below you hereby agree to release and hold harmless the ALS Association of Georgia, Inc. from any legal claims or causes of action you, or any party related to you, may have arising out of the negligence or other actions of the third-party transportation provider.

Patient Signature: ______________________________ **Date:** ____________________________

Representative Signature: __________________________________ **Date:** __________________

Signature of Adult Accompanying Patient: ______________________ **Date:** ________________

Return Form To:
ALS Association of Georgia, Inc.
5881 Glenridge Drive, Suite 200
Atlanta, GA 30328
Or
Fax: 404-636-9949
Email: careservices@alsaga.org

For Office Use Only:

Date received in ALS office: ____________ **Approval Date:** ________________

Authorization Code: __________________________

ALS
ASSOCIATION
Georgia Chapter