

PAUL B. WILLIAMS

ALS TRANSPORTATION PROGRAM

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:

- 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
 - Transport Chair/Manual Wheelchair
 - Able to ambulate, routine transport
 - 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 or rental.
- 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 United of Georgia 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 United of Georgia, Inc., is not a provider of medical or transportation services, and is only arranging for transportation services by a third-party provider. ALS United of Georgia 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 United of Georgia 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 United of Georgia
by Fax: 404-636-9949
or email
careservices@alsgeorgia.org

For Office Use Only:

Date received in ALS office: _____	Approval Date: _____
Authorization Code: _____	

