ALS UNITED GEORGIA

*** Date Received in ALS Office_____ ***
*VOD on File _____ ***

Kostiuk ALS Care Grant Program Application

Person with ALS or PLS Information

Name:_____

Physical Address (No P.O. Box): _____
(MUST BE a Georgia Resident)

City: _____County:_____ State: _____ Zip: _____

Mailing Address (if different from Physical Address): _____

City: _____State: _____Zip: _____

Date of Diagnosis: _____ Date of Birth: _____

Veteran: Yes ☐ No ☐ Hospice: Yes ☐ No ☐ if yes, provider name:

Home Phone: _____ Cell Phone:

E-mail address:_____

ALS Clinic Name:_____Neurologist Name: _____

Proposed grant request amount (not to exceed $1,000): _____

Proposed Use of Funds, if approved:_____

Primary Caregiver/Legal Spouse/ Power of Attorney Information

(Grants may be made payable to Caregiver, *Legal Spouse or Power of Attorney*-provide documentation)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____Relationship to Client: _____

Submit the Application to:

ALS United of Georgia
Phone: 404-636-9909 Fax: 404-636-9949
Email: careservices@alsgeorgia.org

I understand that ALS United of Georgia Care Grant Program is intended for use by those who truly need financial assistance. To the best of my knowledge and belief, the information I provided in the application is true, correct, and complete. I have reviewed the application materials and agree to abide by all requirements, as noted. I acknowledge that these grants are based on the availability of funds and that policies and procedures are subject to change.

(Primary Caregiver, Legal Spouse or Power of Attorney must sign and date this application)

Applicant (Print Name) _____ Date _____

Signature _____ Relationship to Client _____