Kostiuk ALS Care Grant
Reimbursement Chart

ACCEPTABLE REIMBURSEMENTS	***UNACCEPTABLE REIMBURSEMENTS*** ***(not all inclusive)***
HOME CARE	
*Home Care /In-Home Help/Sitter *Patient sitting services by anyone **NOT** living in the home - Must be performed at patient's primary residence	*Residential living - room and board fees *Caregiving provided by anyone living in the home *Lawn care
COMMUNICATION (medically necessary, physician prescription required)	
*Speech generating devices, which may include: • Desktop/laptop computer (*limited to 1 device*) • iPad or other similar tablet (*limited to 1 device*) *Computer software or apps for communication *Augmentative communication devices (*limited to 1 device*)	*Computer repairs *Internet fees or phone bills *Televisions/Apple TV, cable connection, Netflix, email service fees and other subscription services *Virus protectors * Computer accessories: such as headphones, protectors
MEDICAL EXPENSES, EQUIPMENT & SUPPLIES (medically necessary, physician prescription required)	
*FDA approved Rilutek, Nuedexta, Radicava and other ALS Medications (*medications related to ALS diagnosis)* *Insurance Co-Payments for: • Diaphragm pacer & supplies • Durable Medical Equipment • PEG tube supplies/equipment • Bipap, Trilogy & supplies • Prescribed aquatic therapy, physical therapy, occupational therapy and speech therapy • AFO braces/splints • Prescribed hospital beds & mattresses • Clinic and primary care physician's fees (related to ALS) • Medically necessary wheelchair upgrades and repairs (including cushions, seat lift elevator, head array, attendant controls) *Acupuncture/massages/massage therapy *Adjustable bed or mattress, pillows/cushions *Adaptive clothing and shoes *Over the counter medical supplies (such as incontinence supplies, gauzes, nutritional supplements, utensils...) *Ramps and Generators	*Any over the counter or prescription medications non-related to your ALS diagnosis *Health insurance premiums *Groceries *Utility bills (including alarm systems) *Non-ALS related doctor/hospital fees or co-payments (includes vision & dental) *Pool fees or equipment, exercise equipment
HOME MODIFICATIONS (medically necessary, physician prescription required)	
*Building of ramps or installation of lifts (material & labor) *Bathroom accessibility (material & labor) *Doorway accessibility (material & labor)	*Home maintenance and repairs (including driveway and sidewalk repairs, roofing, plumbing repairs) *Interior or exterior painting
TRANSPORTATION (MEDICAL USE ONLY)	
*Rental of vehicle, car service and/or non-ambulance transportation to and from ALS Clinic, clinical study, feeding tube, diaphragm pacer and vent procedure appointments *Purchase of a handicap accessible van *Adaptations/repairs for vehicles to make handicap accessible *Lodging for ALS Clinic appointments (1 room, 2 night limit; does **NOT** include meals)	*Mileage /Gas to and from ALS-related appointments *Automobile maintenance, including, but not limited to tire replacement, oil change, body, or engine repairs

ALS UNITED GEORGIA

Date Received in Office: ___________________
Review Required: Yes_________ No________

Kostiuk ALS Care Grant Program

Billing Statement for Reimbursement

<u>Payee Designation (if other than patient) -- Reimbursement can only be made to the person listed below.</u>
Please remember – this is a reimbursement and cannot be paid directly to the Service Provider.

Client Name: ____Today's Date: ____________________________

Address: ____City: ____________________State: _____Zip: ________

Phone: ____Email:____

Payee ____Relationship to Patient: ____________________
(If not patient, MUST be Caregiver, Legal Spouse or Power of Attorney):

Address: ____City: ___________________State:______Zip:________

FOR SERVICES BEING PROVIDED	**Complete a GRANT SERVICE RECEIPT** (if receipt is not provided to you by service provider) and attach to this completed form.
FOR PURCHASED ITEMS	**Attach copy of actual invoice/receipts to this completed form**

OFFICE USE ONLY
Amount: _________________
Approved By: _____________
Date: ____________________

Please note that it may take up to three weeks to receive a reimbursement check after sending this completed statement. If you do not receive a check from us within three weeks after sending this statement, you may contact 404-636-9909/888-636-9940 or email careservices@alsgeorgia.org to inquire about the status of your reimbursement.

<u>PLEASE REVIEW REIMBURSEMENT GUIDELINES BEFORE SUBMITTING</u>
By signing this form, I am agreeing to honor the reimbursement guidelines listed above.

Client/Caregiver Signature: ____ Date: _________________________

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

ALS United of Georgia
Service Receipt

Instructions: If service provider (driver, sitter, etc.) does not have their own billing receipt, please complete this Service Receipt. Service Provider can be a company or individual.

Please attach this receipt to Billing Statement for Reimbursement along with any other appropriate receipts.

Client Name: ____

Client/POA Signature: ____ *Date:* ______________

Service Provider Information *(MUST BE COMPLETED/SIGNED BY SERVICE PROVIDER)*

Name of Provider: ____

Address: _____________________________ *City/State:* _________________ *Zip:* __________

Home Phone: _______________________________ *Cell:* ______________________________

Date of Service	Service Provided	Number of Hours	Hourly Rate	Total Paid

Service Provider Signature: ____ *Date:* ____________

revised 11/6/23