Grant Application

The Shred ALS Foundation helps to assist patients and/or direct family members affected by ALS. Grants will be awarded based on available funds.

Recipient Information

Date:_____

Patient Name:_____

Spouse/Caregiver:_____

Children (names and ages):_____

Address:_____ Phone:_____

City/State/Zip:_____

Email:_____

Patient Birthdate:_____ Date of Diagnosis:_____

Health Insurance:_____

Policy holder:_____ ID number:_____

Address:_____

City/State/Zip:_____

Phone:_____

Physician name:_____

ALS Clinic name:_____

Address:_____

City/State/Zip:_____

Phone:_____

SHRED ALS

Grant Information:

Please describe in detail your request for assistance. If available, please attach any vendor estimate.

_____
_____
_____
_____
_____

Quote/Cost of request:_____

Amount covered by insurance (if applicable):_____

Have you applied for other assistance or grants? If so, please provide details:

_____
_____
_____

Please describe briefly how this grant will impact your family:

_____
_____
_____
_____
_____
_____

Thank you for your application. All requests will be reviewed by our board of directors and granted as funds are available. Grants will be paid directly to vendors, licensed company, service provider, or business. No individual will be paid for services or reimbursement.