

**CoopStrong – Request for ALS Assistance**

*CoopStrong is a non-profit organization formed to honor the memory of Nelson Cooper. CoopStrong seeks to support the fight against ALS by assisting local families living with this disease and supporting ALS research.*

If you are interested in being considered ALS assistance, please complete this general application form. This will be used to determine your eligibility. Please note that this information may be used to confirm your need for assistance.

**NAME (Person with ALS):** ­­­­­­­­­­­­­­­­­­­­­­ Click here to enter text.

**HOME MAILING ADDRESS:** Click here to enter text.

**HOME PHONE #:** Click here to enter text.

**CELL PHONE #:** Click here to enter text.

**E-MAIL ADDRESS:** Click here to enter text.

**DATE OF BIRTH:** Click here to enter text.

**ALS CLINIC NAME:** Click here to enter text.

**DATE OF DIAGNOSIS:** Click here to enter text.

**NEUROLOGIST NAME:** Click here to enter text.

**Primary Caregiver Information:**

Name: Click here to enter text.

Address: Click here to enter text.

Phone #: Click here to enter text.

Email address: Click here to enter text.

Relationship to Patient: Click here to enter text.

**Please describe the amount and type of assistance you are requesting?**

Click here to enter text.

**Examples of needs we can assist with:**

* Respite and/or Nursing care
* Communication: electronic writing tablets, communication apps, speech generating devices
* Medical expenses: prescriptions, copays for ALS clinic visits, respiratory procedures and respirator devices, nutritional formula (example: Boost/Ensure)
* Durable medical equipment such as: wheelchairs, medical wheelchair cushion, wheelchair repairs, wheelchair batteries, lift chairs, Hoyer lifts and slings, shower/bath chair, bedside commode, orthotic devices.
* Home Modifications such as: grab bars, raised sinks, accessible toilet/seat risers, bidget, shower or bath modification, door widening, expandable door hinges, light switches, door knobs, ramps.
* Transportation: mileage/gas for visits to ALS clinic
* Personal needs: rent, utilities

***\*\*Please note that payment cannot be provided directly to an individual, but will be disbursed to the company or entity on the patient’s behalf. \*\****

**I confirm that my insurance and/or veteran’s benefits will not cover the expenses for which I am requesting help. I understand that support from CoopStrong is intended for use by those who truly need financial assistance and will benefit the patient and/or the family of the person living with ALS. I confirm that all information provided is accurate and I understand that approval of all requests will be based on available funds**.

**APPLICANT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP TO PERSON WITH ALS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For internal purposes only:***

Request approved/denied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form of assistance provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_