ALS Support Services Application

Individuals Name: Mr. Mrs. Ms._____

Age: _____

Address where you live: Street: _____
City: _____ Zip Code: _____

Phone Number: Home: _____Work: _____ Mobile: _____

Email Address: _____

Is this a - home: _____ apartment: _____ residential care: _____ Other: Please Specify: _____

Do you live alone: Yes _____ No _____?

Can we contact you directly: Yes _____ No _____ If no, who can we contact on your behalf?

Contacts Name: _____Relationship: _____

Phone Number: Home: _____Work: _____ Mobile: _____

Email Address: _____

How did you hear about our organization?

_____

Physicians Name: _____

Social Workers Name: _____

Insurance: _____

When were you diagnosed with ALS? _____

How would describe your current condition?

_____
_____
_____
_____
_____
_____

What kinds of assistance do you need: Please be as specific as possible,

Food allowance

Assistance with living expenses

Companionship

Shopping assistance

Doctor appointment visits

Utilities

Medical

Other:

_____

_____

_____

_____

Do you have any equipment specific to ALS you no longer use that you might consider donating to another person with ALS?

_____

_____

_____

_____

Is there any other information that might be helpful to us?

_____

_____

_____

_____

Date Application Received: _____ Reviewed by: _____

Services Approved:

_____

_____

_____