TEAM CURE ALS FOUNDATION

GRANT APPLICATION

APPLICANT INFORMATION		
Name:		
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	
Email:		

PERSONAL INFORMATION	
ALS Clinic Name:	Neurologist Name:
Date of Diagnosis:	Date of Birth:
Grant Amount Requested:	
What will the grant funding be used for? Are there other circumstances we should be aware of?	
How many dependents live at home with you?	
Permission to Use Likeness: (Please circle) Yes No	Permission to Use First/Last Name: (Please circle) Yes No
Where did you hear about us?	

PRIMARY CAREGIVER INFORMATION		
Name:		
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	
Email:		
Relationship to Patient:		

The information provided by applicant is true and accurate to the best of my knowledge. I authorize TEAM Cure ALS Foundation to verify the information provided on this form.	
X	Date
Applicant - Patient or Caregiver (Please Print Name)	
X	
Signature	Relationship to Patient

FOR OFFICE USE ONLY	
Service Requested:	Approved: (Please Circle) YES NO
Amount Approved:	Date:
Authorized Signature:	Initials:

Grant Application Updated: 02/2014

www.**TEAMCUREALS**.org