ALS Financial Assistance Program Application

Funding Period: August 1, 2024 - January 31, 2025
Application Deadline: January 1, 2025

Application approvals are based on available funds, and approvals are not guaranteed.

Please do not include receipts with your application.

Applicant Information:

Name: ___________________________________

Date of Birth: ______________________________ Date of ALS Diagnosis: _______________________

*Physical Address: *(No PO Box)* ____

City: _________________________________ State: ______________ Zip: ______________________

Mailing Address: *(If different from physical address)* ____

City: _________________________________ State: ______________ Zip: ______________________

Mobile Phone: _____________________________ Alternate Phone: ____________________________

Email Address: _____________________________

Neurologist Name: _________________________ ALS Clinic Name: ____________________________

Primary Caregiver Information: *(This may include a family caregiver, spouse, or family member.)*

Name: ___________________________________

*Physical Address: *(No PO Box)* ____

City: _________________________________ State: ______________ Zip: ______________________

Mobile Phone: _____________________________ Alternate Phone: ____________________________

Email Address: _____________________________

Relationship to Applicant: ____________________

**Note: Oregon or SW Washington address. (PO Boxes will not be accepted.)*

Headquarters Office: 825 NE Multnomah St., Suite 940, Portland, OR 97232
Phone: 503-238-5559 • Fax: 503.296.5590 • www.alsnorthwest.org

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Please sign and date this application.
Mail, fax, or email to our office:

ALS Northwest
825 NE Multnomah St., Suite 940
Portland, OR 97232
Phone: 503-238-5559 ext. 100
Fax: 503-296-5590
Email: CareServices@alsnorthwest.org

The information I provided is true, correct and complete. I have read the ALS Financial Assistance Program documentation and agree to abide by all requirements as noted. I understand that approval will be based on available funds, and once approved I will have access to funds for the current funding period.

______________________________	______________________________
Applicant (Print Name)	Applicant (Signature)
______________________________	
Date	

I, the undersigned, hereby sign on behalf of the applicant, with their explicit consent and in acknowledgment of their physical inability to sign this form.

______________________________	______________________________
Applicant Proxy (Print Name)	Applicant Proxy (Signature)
______________________________	______________________________
Date	Relationship to Applicant

Policies and procedures are subject to change.