

ALS Financial Assistance Program Application

Funding Period: February 1, 2025 - July 31, 2025

Application Deadline: July 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.)*



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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.

