

Application Form for Financial Support

Please complete all sections of the form. An incomplete form may delay the processing of your request.

Program you wish to apply for					
*Please refer to the Information Sheet for a full description of each initiative.					
☐ Quality of Life: (up to \$1,000/family/year)					
☐ Technical aids and/or minor home adaptations: (To be completed by a healthcare professional)					
☐ Comfort and Care					
☐ Youth support (up to \$300/child under age 18)					
Number of children:					
Names and dates of birth:					
☐ Seize the day (special wish / memorable activity)					
- Brief description of your wish:					
Information about the diagnosed p	erson				
Are you registered with ALS Quebec? ☐ Yes ☐ No ☐ I don't know					
Full Name:	: 163 110	Date of birth:			
Phone:		Email:			
Frione.		EIIIaII.			
Address:	City:		Postal code:		
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Applicant information (To be completed only if the application is submitted by someone other than the					
diagnosed person)					
☐ Healthcare professional (please leave this section blank and complete Annex A below)					
□ Caregiver					
☐ Other					
Full Name:		Relationship with the afflicted person:			
Phone:		Email:			
Request details					
Describe the request and estimated costs (See the Information Sheet for eligible expenses for the "Comfort					
and Care" initiative):					
Have you applied to any public programs or insurers? ☐ Yes ☐ No					
If yes, please specify:		<u> </u>			
Declaration Declaration					
☐ I certify that the information provided is accurate. I understand that this grant is complementary to other existing					
assistance and that ALS Quebec reserves the right to accept or refuse my application.					
Signature		Date			
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ANNEX A - Professional Recommendation Form

This form accompanies an application to the "Assistive Devices and/or Minor Home Adaptations" initiative. It must be completed only if you are a healthcare professional and wish to submit a request for this initiative.

Identification of the healthcare professional				
Identification of the healthcare professional	Desfersions			
Full Name:	Profession:			
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Phone:	Email:			
Institution or Organization:				
Recommendation details				
Please describe the specific needs of the person living with ALS and recommendations for technical aids and/or minor home adaptations				
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Have you applied to public programs or insurers?	□ Yes □ No			
Click here for a list of available resources.				
If yes, please specify:				
Estimated Costs				
Please provide an estimate of the costs related to assistive devices and/or minor home adaptations.				
Please attach any quotes or relevant documentation supporting the cost estimate to your request.				
Attestation				
\Box I certify that the above recommendations are based on a professional assessment of the needs of the				
person living with ALS.				
☐ I confirm that I have obtained the consent of the affected person or his/her representative to transmit this				
information.				
Signature	Date			
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