The Hope-JG Foundation
Grant Application

This grant application is intended to assist persons living with ALS (PALS) and/ or caregivers providing for PALS. The grant is intended to help with medical expenses, medical equipment, respite care, travel, or other needs PALS may have. These grants are limited to $1500 and are paid directly to the vendor or service provider.

Grant Application Process

- Please fill out the complete application. Once the application is received, you will receive notification of receipt. It will be reviewed by the Foundation's Board of Directors. Please allow sufficient time for review and approval.
- Possible Grant uses may include, but are not limited to:
  - Medical/ Pharmaceutical Expenses
  - Home Health Assistance
  - Travel Costs
  - Home and Auto Modifications
  - Medical Equipment/ Supplies
- Funding of all grants will be based on need and available resources. If the full amount cannot be funded, the Foundation will work with the patient and caregiver to assist in the best way possible.
- Once your grant application is approved, the Foundation will ask for a bill or invoice and will pay the bill directly to the provider. If the bill has already been paid, proof of payment will be requested and the grant recipient will be refunded.

Please make sure your application is signed and dated when submitted.

Mail or Fax the Application to the Foundation at:
The Hope-JG Foundation
PO Box 1805
Windham, ME 04062
Fax: (888) 651-4620

Questions or Comments? Please contact:
Linda Gregoire – 207-415-5849 or our office number at 207-613-4543

Grant Application

Date: _____

PALS Information:

Name:		
Physical Address:		
City:	State:	Zip:
Mailing Address (if different from Physical Address):		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email Address:		
ALS Clinic Name:	Neurologist Name:	
Date of Diagnosis:	Date of Birth:	
Grant Amount Requested:	Health Insurance Company	Medicare? ☐ Medicaid? ☐
What will this grant funding be used for?		
Please list any additional sources of funding you have requested to address this need and whether the request was granted, even partially. Please include monetary gifts from family & friends.		

THE HOPE-JG FOUNDATION
BECAUSE EVERY FAMILY WITH ALS MATTERS.

Primary Caregiver Information: *

Name:		
Physical Address		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email Address:		
Relationship to Patient:		

I understand Foundation grants are intended for use by those who truly need financial assistance. To the best of my knowledge and belief, the information I provided above is true, correct, and complete.

[ ]. If my application is approved and I receive grant money, physical equipment and/or services from The Hope-JG Foundation or as a results of its efforts on my behalf, I agree to provide a written testimonial for the Foundation to use to in its fundraising and promotional efforts.

_____ _____

Applicant – Patient or Caregiver (Print Name) Date

_____ _____

Signature Relationship to Patient

*** Primary Caregiver is typically a Spouse, sibling, adult child or other relative or close friend who devotes the most time attending to the personal needs of the patient.**