



HEARTS for ALS NY, INC.



PATIENT/FAMILY GRANT REQUEST

1. RECIPIENT NAME:
2. RECIPIENTS ADDRESS:
3. TELEPHONE: E-MAIL:
4. COUNTY:
5. PAYEE: (if different from recipient)
6. PAYEE ADDRESS:

USE OF FUNDS:

BRIEFLY DESCRIBE THE NEED/USE OF FUNDS THE PATIENT IS APPLYING FOR:

I certify that the information provided is correct, that all funds will be used according to the above description.

Signature of Recipient/Representative:

Approval:

Date:

HEARTS for ALS NY, INC.