HEARTS for ALS NY, INC.

PATIENT/FAMILY GRANT REQUEST

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

USE OF FUNDS:

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

I certify that the information provided above is correct, that all funds will be used according to the above description. No other payments have been received or accepted for the same purposes.

Signature of Recipient:_____ Approval:_____
Date:

Approval:_____

Hearts for ALS NY, Inc., 1899 South Avenue Rochester, New York

585-943-3730 | www.heartsforalsny.org

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MONROE WHEELCHAIR

HEARTS for ALS NY, INC.

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