THE SUSIE FOUNDATION

Please note: This form should only be completed if the service provider does not have their own billing receipt. One completed, please attached to the Billing Statement for Reimbursement.

Grant Service Receipt

Patient Name: _____
Last *First* *M.I.*

By signing this form, I am agreeing to honor the reimbursement guidelines of the program and acknowledge that this submission only contains the costs incurred by myself or my family directly as they relate to my or my loved one's ALS diagnosis.

Patient/Caregiver Signature: _____ Date: _____

Service Provider Information (Must be completed/signed by service provider)

Name: _____

Business Name (if applicable): _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Type of Product or Service: _____

Total amount billed (in USD): _____ If hourly, please note cost per hour: _____

Service Provider Signature: _____ Date: _____

Please note that if you have any questions regarding this form, or anything else related to this program, you may contact Ryan Matthews at (203) 217-4884 or email ryan.matthews@thesusiefoundation.org at any time.

Please mail this completed form, with all appropriate paperwork to:
The Susie Foundation, 66 Cook Lane, Beacon Falls, CT 06403