HOWARD I. ABRAMS IN-HOME CARE GRANT PROGRAM APPLICATION

Name: ___________________________________

Address: _________________________________

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County: __________________________________

Phone: ____________________ Date of Birth ____________

Email: ____

Contact person: ______________________

Relationship: ________________________

Phone: ____________________________

I am currently receiving help at home from the following agencies:

☐ County Office of Aging or Attendant Care Programs ☐ Hospice

☐ VA (Veterans' Administration) ☐ Insurance funded RN/PT/OT

☐ Private Caregiver/Agency ☐ LTC Policy (Long Term Care) ☐ None

Agency	Contact Person	Phone	How often?

I have applied to the following programs:

☐ County Office of Aging or Attendant Care Programs ☐ VA ☐ LTC Policy

Agency	Contact Person	Phone

This program has limited funds, therefore, in general, Howard I. Abrams Funds are not to be used to provide in-home care services where this service is adequately covered through a LTC policy or community agency.

I am requesting _____ hours per day, _____ days per week. Preferred time of day ________________

(Hours can range from 2 to 12 weekly) dependent upon circumstances.

What types of care does the patient currently require? (Check all that apply)

☐ Bathing ☐ Meal Preparation ☐ Transfers (Do you have a hoyer lift? Y / N)

☐ Dressing ☐ Feeding (Do you have a feeding tube? Y / N)

☐ Light Housekeeping ☐ Range of Motion Exercises ☐ Other (explain)

(over)

Are you utilizing any equipment to help with your breathing? (Check all that apply)

☐ BiPap ☐ Volume Ventilator ☐ Ventilator with tracheotomy

If yes, how many hours do you use the machine?

☐ 2-4 hours ☐ 6-8 hours ☐ 8-10 hours ☐ Overnight ☐ 24 hours ☐ Other ___________

Are you currently using any of the following equipment?

☐ Suction Machine ☐ Cough Assist ☐ Nebulizer

If yes, how often do you use the equipment?

____

Describe current physical condition:

Weight: __________ Height: __________

Please check equipment you utilize: ☐ **Manual wheelchair** ☐ **Power wheelchair** ☐ **Walker**

Do you use a communication device? ☐ Yes ☐ No If yes, what type? ____________________

Pets in home? ☐ Yes ☐ No If yes, type of pet? ________________________________

Smoking in home? ☐ Yes ☐ No

Are there issues impacting primary caregiver that you would like us to be aware of? (i.e.: young children, dependent elderly, employment responsibilities, or caregiver's health).

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By agreement with The ALS Association, I understand that if approved for the Howard I. Abrams In-Home Care Program, services will be provided by a preferred provider of The ALS Association. I authorize the In-Home Care Coordinator to release and obtain any information necessary to complete this referral.

I have read the Howard I. Abrams In-Home Care Program guidelines and I understand that services will be provided on a limited basis.

Patient Signature: ____ **Date:** _________________

RETURN FORM TO:

Wendy Barnes, LSW
ALS Association Greater Philadelphia Chapter
321 Norristown Road, Suite 260
Ambler, PA 19002
or
Fax: 610-791-1283

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