Respite Care Assistance Application

Contact Information of person filling out application on behalf of client

Name _____

Email_____ Phone number_____

Parkinson's Client Information

Last Name _____First Name_____

Street _____Apt. _____

City _____County_____ State _____ Zip _____

Date of Birth _____ Phone _____Email _____

Neurologist's Name_____

When were you diagnosed with PD_____ Current Major Symptoms _____

_____

What type of equipment do you use?_____

Are you employed? _____ Occupation _____

Spouse employed? _____Occupation _____

Estimated monthly household income? _____Monthly expenses? _____

Veteran? ☐ Yes or ☐ No Currently in contact with VA? ☐ Yes or ☐ No

Please include a written confirmation of diagnosis of PD from your physician.
**Required for review of application*

- I understand this request for home care is for temporary, short-term assistance.
- Participation in this program is based on need and the availability of funds.

I hereby release and hold the Michigan Parkinson Foundation, Inc. harmless from, against, and in respect of all claims, injuries, actions, demands, suits, losses, liability, or other damages that may be incurred as a result of accepting goods or services.

I attest that, to the best of my knowledge and belief, all information in the above referenced data reported is accurate and complete.

Applicant/Caregiver Signature: _____ Date: _____

Please send completed application to Stephanie Woznak at StephanieW@parkinsonsmi.org or fax to 248-433-1150 or mail to 30400 Telegraph Rd. Suite 150, Bingham Farms, MI 48025

30400 Telegraph Road • Suite 150 • Bingham Farms, MI 48025
248.433.1011 • Fax: 248.433.1150 • 800.852.9781 • www.parkinsonsmi.org

The following information is voluntary, and responses will not be used in determining grant approval. The information you provide will be kept anonymous. If you choose to answer the following questions, we will use the information you provide for data collection. We may share the aggregate data with current and potential funders and other relevant stakeholders.

Age of PD patient_____Age of primary caretaker_____ County of residence_____

Please circle the demographic information related to the PD patient.

Marital Status: Single Married Divorced Widowed Separated Domestic Partnership

Race: White African American Asian American Indian Pacific Islander

Residency: Single-family home Independent apartment Senior housing

Type of medical insurance: Medicare Medicaid Private Carrier None

Services utilized for PD: Home Health Respite Speech/Language Support Groups Occupational Therapy Physical Therapy

Who provides the services? _____ Who pays for the services? _____

What additional service(s) do you need?

_____

_____

Do you receive any natural (unpaid) support? ☐ Yes ☐ No

If Yes, who provides the support? Family Friends Neighbors Religious institution

_____

How much are you paying each month to manage your Parkinson's Disease? (co-pays, medications, equipment, home health, transportation, etc.)?_____

_____

Please provide any additional information you feel would be helpful for us to know.

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