Respite Assistance Application

The MPF Caregiver Respite Assistance program is designed to help alleviate caregiver burnout. This program is for in-home care, adult day centers, and short-term stays at facilities when 24/7 overnight care is required.

To qualify for our respite care program, the following is required:

- Completed Application
- Written confirmation of Parkinson's disease diagnosis from your physician
- Financial Need
- Resident of Michigan *Please note that funding cannot be used in long-term alternative living situations (i.e. group homes, senior living, or assisted living facilities)

Primary Caregiver Information

Name _____

Email_____ Phone number_____

Who referred you to apply for the Caregiver Respite Assistance Program?

_____

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? _____

*Proof of income may be requested

Please see second page to complete application

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

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

Veteran: Yes or No Currently in contact with VA: Yes or No

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

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.

_____

_____

_____

_____

Include the written confirmation of diagnosis of Parkinson's disease 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 respite@parkinsonsmi.org or fax to 248-433-1150 or mail to 30400 Telegraph Rd. Suite 150, Bingham Farms, MI 48025