Respite Care Assistance

QUALIFICATION APPLICATION

Last Name ______________________First Name ____

Street ____Apt. _______________________

City ____________________________County__________________ State ________ Zip _____________
Date of Birth __________________ Phone _____________________Email ________________________
Physician'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 ____

What is your monthly household income? ______________Monthly expenses? ____________________

Please include a written confirmation of diagnosis of PD from your physician.

The Foundation may require documentation of all or some of the above items.

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 Signature: ___________________________________ Date: ______________________________

Dedicated to People Living with Parkinson's

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; **please do not write your name on this form.** 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.
____
____
____

30400 Telegraph Road • Suite 150 • Bingham Farms, MI 48025

248.433.1011 • Fax: 248.433.1150 • 800.852.9781 • www.parkinsonsmi.org