



Respite Care Assistance Application

Contact Person _____

Email _____ Phone number _____

QUALIFICATION APPLICATION

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 _____

What is your monthly household income? _____ Monthly expenses? _____

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

- The Michigan Parkinson 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/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

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.

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