

Parkinson Partners Respite Care Grant Program Application

Parkinson Partners of NW PA

PO Box 10547, Erie, PA 16511

Phone/Text: 814-899-3030

Email: info@parkinsonpartners.org Website: www.parkinsonpartners.org

The Parkinson's Respite Care Program will provide \$500 grants renewable annually in July. After receiving your application and determining your eligibility, Parkinson Partners will send you an approval notification. You may then use the agency of your choosing. You must provide paid receipts from the agency and Parkinson Partners will reimburse you up to \$500/annually. Any cost above the \$500 will be your responsibility. Funds will not roll over. Any funds not used within the grant year, will be forfeited. Those living in assisted living/skilled nursing care facilities or outside of Erie County are not eligible.

Person with Parkinson's or Parkinsonism (PWP) Information:

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Male or Female: _____ Date of Birth: _____

PD Diagnosis or Parkinsonism: _____

Neurologist's Name: _____ Phone: _____

Care-partner Information:

Full Name: _____

Relationship to Person with Parkinson's: _____

Address: (If different from PWP) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Additional Questions:

Is the person with Parkinson's disease (or parkinsonism) or the care-partner eligible for reimbursement for the same service from another source? (Circle one) **YES NO**

Is the person with Parkinson's disease (or parkinsonism) a resident of a care facility, such as a personal care home, assisted living facility, or nursing home? (Circle one) **YES NO**

I (caregiver), _____, verify that the information provided in this application is accurate as of this date to the best of my knowledge. I understand and agree that the role of the Parkinson Partners Respite Care Grant Program is that of an intermediary, with the sole purpose of providing financial assistance for the purchase or provision of respite care. I understand and agree that the Parkinson Partners assumes no liability or obligation to provide or manage the above stated services, and takes no responsibility for the respite care provider's quality of care. Furthermore, if additional services are desired over the approved \$500 grant amount, it will become my (client) sole financial responsibility.

Client Signature

Date

Respite Care Provider Information:

Name of Company or Provider: _____

Contact Person: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Relationship to Care-partner or PWP, if any: _____

Please provide this information each time you submit paid receipts for reimbursement.

For more information, please reach out to us:

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