Parkinson Association of Minnesota
Respite Care Program Application Form

Primary Caregiver Information:

Name:____

Address:____

City:_____________________________State:_____Zip:__________

Home Phone:__________________Work Phone:_________________

Relationship to Patient:_____________________________________

Patient Information:

Name:____

Address:____

City:_____________________________State:_____Zip:__________

Home Phone:__________________Work Phone:_________________

Date of Birth:_______________________________Sex: Male/Female

Diagnosis:____

Date of Diagnosis:____________________________________

General Information:

1. Who helps you, the primary caregiver, in caregiving on a no-charge basis? Check all that apply:
   No One_____Family_____Friends_____Church_____

   Home Care Service_____Other(specify)__________________
2. How often do you, the primary caregiver, receive caregiver assistance?
   Never_____0-4hrs/wk_____5-10hrs/wk_____

   11-20hrs/wk_____20hrs/wk_____
3. Check any of the respite care services you plan to use if granted this financial assistance:
   In-Home Companion/Aide_____Live-In Companion/Aide_____

   Adult Day Center_____Short-term Skilled Nursing Facility_____

   Short-term Residential Care Home_____
4. Do you have medical or long-term care insurance which will contribute to the payment of respite care?
   Yes_____No_____If Yes, describe coverage:______________________

   ____

I (caregiver), ____, verify that the information provided is an accurate reflection of the situation as of this date. I also understand that the sole role of the Parkinson Association of MN Respite Program is that of an intermediary and, apart from offering financial assistance for the purchase of respite care, the Parkinson Association of MN Respite Program has no role in the management of or the responsibility for the care provided.

____ __________________
Signature Date