



Parkinson Association of Minnesota
Respite Care Program Application Form

Primary Caregiver Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address _____

Relationship to Patient: _____

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

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