AMERICAN PARKINSON DISEASE ASSOCIATION
RHODE ISLAND CHAPTER
Strength in optimism. Hope in progress.

Patient Aid Scholarship Program
APPLICATION

APDA's mission: Every day, we provide the support, education, and research that will help everyone impacted by Parkinson's disease live life to the fullest.

APDA Rhode Island Chapter offers a Patient Aid Scholarship Program designed to provide financial support to people with Parkinson's disease (PD) and their families, who are in need of financial assistance for programs, services and/or activities listed below. Approved applicants will be granted up to $300.00 once per calendar year (January – December). Funds are limited and will be awarded on a first come basis.

- **Exercise/Wellness**: Supports costs associated with exercise/wellness programs and activities that focus on improving and maintaining the health for persons with PD, such as, but not limited to: boxing, dancing, yoga, tai-chi, physical therapy, occupational therapy, music therapy, etc.
- **Medication**: Defrays expenses not covered by other programs or health insurance.
- **Respite/Adult Day Program**: Subsidizes the cost of respite care for the person with Parkinson's disease, to enable care partners to take time away to rejuvenate.
- **Assistance at Home**: Supports expenses for home services, such as housework, light yardwork, snow shoveling, and other tasks that a person with PD or a care partner are not able to complete.
- **Transportation:** Subsidizes costs associated with travel to and from doctor's appointments, support groups, and other events for those who are no longer driving or for whom driving is significantly limited due to the effects of Parkinson's disease.
- **Childcare Assistance:** Subsidizes the cost of childcare for people with Parkinson's.
- **Adaptive Equipment:** Offsets costs associated with the purchase and/or installation of equipment or modifications needed in the home to aid in activities of daily living, such as, but not limited to: grab bars, hand rails, widening doorways, bathroom accessibility, etc.

Instructions:

1. Complete Patient Aid Scholarship Program Application
2. Mail or email the completed application along with required documentation to:
   APDA Rhode Island Chapter
   PO Box 41659
   Providence, RI 02940
   apdari@apdaparkinson.org

Applications are reviewed on a rolling basis and applicants will be notified within sixty (60) days of receipt. These scholarships are awarded on a first come basis and are based on availability of funds. The program is subject to change or discontinuation with limited notice.

For information about Parkinson's disease, information and referrals to services in the community, events and volunteer opportunities or general questions, please contact 800.651.8466 or email apdari@apdaparkinson.org

Applicant and Care Partner Information
("Applicant" has Parkinson's disease or Parkinsonism diagnosis)

Total Amount Requested: $
Up to $400 one-time payment per calendar year (January-December) can be awarded.

This scholarship is intended to be used for the following program(s) (check all that apply):

Exercise/Wellness
Medication
Respite/Adult Day Program
Assistance at Home
Transportation
Childcare
Adaptive Equipment

APPLICANT Full Name:

To better understand the people we serve, please provide the Applicant's: DOB Year of Diagnosis

CARE PARTNER (if applicable) Full Name:

Care Partner Relationship to Applicant:

Address:

City: State: Zip Code:

Phone: Applicant Care Partner

Email: Applicant Care Partner

Have you applied for this scholarship or any other related financial award from APDA in previous years? Yes No

***If Yes**, and Parkinson's disease diagnosis can be verified by physician on previous paperwork submitted for an APDA Program, then the Physician Confirmation section can be left blank.*

Physician Confirmation:
The applicant is currently under my care and has a diagnosis of Parkinson's disease or Parkinsonism.

Physician Name (please print):

Healthcare Institution:

Phone:

IMPORTANT: Physician's Stamp must be on application, or a separate letter from physician confirming the applicant's PD diagnosis on the physician's letterhead along with their signature can be attached.

Physician Letter Attached, or
Physician Stamp ➡

Eligibility Guidelines

To qualify for this Patient Aid Scholarship Program, the applicant agrees to:

- Complete and submit the entire application.
- Provide physician's confirmation of a diagnosis of Parkinson's disease or Parkinsonism.
- Understand this program is intended for individuals with PD in need of financial assistance.
- Reside within the APDA Rhode Island Chapter area.
- Resides in the community, not in a rehabilitation center or long-term care or skilled nursing facility.
- Agree to be on the APDA Rhode Island Chapter mailing list.
- Allow APDA to contact you to provide additional information and educational materials.

Client Consent: I understand and agree **(please check each box)**:

☐ To the guidelines and requirements of this program and request financial assistance from APDA.

☐ That the applicant/care partner is solely responsible for choosing the provider for the programs this scholarship is intended to be used for and that APDA assumes no responsibility for choice of provider.

☐ That any additional expenses beyond the approved amount will be the applicant's sole responsibility.

☐ To provide copies of receipts/invoices to APDA for the purpose this scholarship was intended to be used.

Release of Liability: On behalf of myself, my heirs, successors, and assigns, I hereby forever release, indemnify, and hold the APDA, its officers, directors, employees, and agents, harmless from and against any and all injuries, deaths, claims, liabilities, losses, damages, costs, and expenses arising from or in any way related to, my participation in this program. I intend this release to be effective, regardless of whether the claim of liability is asserted in negligence, strict liability in tort, or other theory of recovery.

The applicant and, if applicable, a care partner (or someone who is legally authorized to sign on his/her behalf) must sign or make some mark indicating their agreement of the guidelines and requirements as mentioned above.

☐ *Checking this box acts as a signature indicating that you agree to the guidelines and requirements outlined above.*

Applicant Signature _____ Date: _____

☐ *Checking this box acts as a signature indicating that you agree to the guidelines and requirements outlined above.*

Care Partner Signature (if applicable) _____ Date: _____

FOR APDA USE ONLY:

Date received: Click here to enter a date. Date approved: Click here to enter a date.
All application requirements received: Choose an item. Amount Approved: $
Date scholarship payment was issued: Click here to enter a date.
2020-V3.0

CLEAR FORM PRINT FORM