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. 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.
- **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.
- **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
   Mail or email the completed application along with required documentation:
   APDA Rhode Island Chapter
   PO Box 41659
   Providence, RI 02940
   - or scan/email to:
   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 a diagnosis of Parkinson's disease or Parkinsonism)

Total Amount Requested: $ _____
(up to a $300 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
☐ Respite/Adult Day Program
☐ Assistance at Home
☐ Adaptive Equipment
☐ Other (Please indicate)
_____

Applicant Full Name: _____
To better understand the people we serve, please provide the Applicants: Year of DOB _____ Diagnosis _____

Care Partner Full Name (if applicable): _____

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 or Parkinsonism diagnosis can be verified by physician signature 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, 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 & requirements of this program & 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.

_____ Click here to enter a date.

Applicant's Signature Date

_____ Click here to enter a date.

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