

Minnesota Chapter

PATIENT GRANT PROGRAM

PROGRAM DESCRIPTION:

Funds will be distributed on a first come, first serve basis based on availability of funds.

The APDA mission is to “Ease the Burden, To Find a Cure”. The Minnesota Chapter has implemented a set of Patient Grant Programs to partially address the mission to “Ease the Burden” for people with PD and their families. They are designed for member families to apply for and receive monetary grants that help subsidize various expenses. Grants will be given in an amount of \$500.00 per year but may be less based on the need and availability of funds.

- **Exercise:** A program to reimburse costs associated with exercise programs that focus on treatment to improve and maintain the health of a person with PD.
- **Medication:** A program to help defray expenses not covered by other programs or health insurance.
- **Respite Care:** A program designed to help subsidize the cost of respite care. Respite Care enables care partners to take time away from their responsibilities to rejuvenate. A Respite Care grant will be limited to one grant per calendar year per family.
- **Assistance at Home:** A program to help cover expenses for home services, such as housework, light yardwork, snow shoveling, and other tasks that may not be able to be done anymore by a person with PD or a care provider.
- **ELIGIBILITY:**

To qualify for a Support Grant, the applicant must:

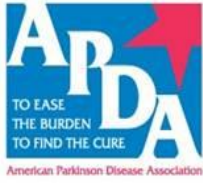
- Be on the APDA Minnesota Chapter mailing list.
- Reside within Minnesota.
- Have a diagnosis of Parkinson’s Disease or be caring for a family member at home with a diagnosis of Parkinson’s disease.
- Complete and submit the entire Patient Grant Program Application.

SUBMIT COMPLETED APPLICATIONS TO ANY OF THE FOLLOWING:

Email to: **anushka.mohideen@allina.com**

Mail to: APDA-MN c/o United Hospital
333 N Smith Ave., MR 63201
St. Paul, MN 55102

Fax to: **651-241-6505**



Minnesota Chapter

PATIENT GRANT PROGRAM APPLICATION

Date: _____

Grant Choice

- EXERCISE**
- MEDICATION**
- RESPIRE CARE**
- ASSISTANCE AT HOME**

Have you applied before?

- No**
- Yes: If so, date last applied** _____

Name of Person with PD	
Caregiver Name	
Relationship to Individual with PD	
Address (include, street, city, zip)	
Phone	
Email	
How did you hear about this program? ___ APDA (check all that apply) ___ My Neurologist/Physician ___ Other: _____	
Please describe the reason for the request and how the grant money will be used: 	

My signature below indicates that I have reviewed the guidelines and requirements for this program, and request financial assistance from the APDA Minnesota Chapter (“Chapter”). I agree to use the funds for respite or complementary care services as outlined above in the program description. I understand I am solely responsible for choosing the provider, and that the Chapter has no responsibility for the choice of provider. I also understand the Chapter assumes no liability for claims arising out of any area by this program. I hereby waive any and all claims, damages, lawsuits, or other liability arising from the program.

By signing below I acknowledge that MN APDA is the only Parkinson’s association from which I am applying for a grant.

Applicant’s signature: _____ Date: _____

Please sign and date application before submitting. Please allow time for processing.

Provider/Physician:

The above-named Participant is currently under my care and has a diagnosis of Parkinson Disease.

Provider/Physician Printed Name

Provider/Physician Signature

Date

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333 N. Smith Ave, MR 63201
St. Paul, MN 55102

Fax to: 651-241-6505

Questions? Please call Anushka at 651-241-8297

Return completed application to:
APDA-MN Chapter
c/o United Hospital
333 North Smith Ave.
MR 63201
Saint Paul, MN 55102
Fax # 651-241-6505 or
Fax # 651-241-6505

