
Eligibility Criteria for the RPN Respite Care Grant Program

1. For the care partner to be eligible for the grant, the patient's diagnosis of Parkinson's disease must be verified, in writing, by a physician, PA, social worker or nurse.
2. The care-partner may not apply for this grant if either the person with Parkinson (PWP) or care-partner is receiving reimbursement for the same service from another source.
3. The PWP must not be a resident of an assisted or long term care facility.
4. The service by the agency selected by RPN must be provided within Monroe County.
5. The care-partner must use the services of an agency designated by RPN.
6. If approved, the grant will fund a minimum of 4 hours up to a maximum of 12 hours of companion care per applicant.
7. The grant recipient may use the grant for one or several events as long as it is used within 4 months of the date of grant approval.
8. Verification of use must be provided to RPN by both the grant recipient and the agency used for the service in order for the agency to be reimbursed otherwise the applicant may be backcharged by RPN for any costs incurred by the service. **The grant recipient or care partner must email rpnrespitgrant@gmail.com or call (585) 770-1570 and leave a message within 1 week of receiving all services specified in the grant award letter.**
9. Grant recipients may reapply no more than once per year, pending availability of funds.
10. Preference for grant approval will be given to applicants who did not receive a grant within the previous 12 months of current application date.
11. The grant recipient must use the agency selected by RPN to provide the needed services.
12. **Failure to abide by these Eligibility Criteria may result in the grant being denied or rescinded.**

How does a care-partner apply for the grant and how are the funds administered?

The care-partner must complete the attached application and submit via email to rpnrespitgrant@gmail.com or by mail to PO Box 18606, Rochester NY 14618. The applicant will be notified in writing, by RPN, if the application has been approved within one month of receipt of the application by RPN. Once the application is approved, RPN will contact our partner agencies to establish care for the awarded hours of service. The agency will reach out to the applicant to schedule.

Companion Care Definition

What companion care includes:

- Socialization: Companions can help people interact with others through conversation, games, and social activities
- Emotional support: Companions can provide comfort and support
- Household tasks: Companions can help with light housekeeping, meal preparation, laundry, and dishes
- Transportation: Companions can help people get to appointments and other places
- Errands: Companions can help people run errands, like grocery shopping
- Planning: Companions can help people plan activities and schedule appointments

What companion care EXCLUDES:

Companion care does not allow for services required to be provided by a skilled and licensed professions. These excluded services include assistance with bathing, dressing or medication management.

Respite Care Grant Application

Rochester Parkinson Network
 PO Box 18606
 Rochester, NY 14618
 Phone: (585) 770-1570
 Email: rocparknet@gmail.com
 Web: www.rocparknet.org

Date of Application:

Person with Parkinson's (PWP) Information:

Full Name:		
Address:		
City:	State:	Zip:
Email Address:		
Date of Birth:		

In order to qualify for these funds from RPN, RPN may request a certification statement from your physician to confirm the diagnosis of PD.

Primary Physicians Name:	Phone:
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Date or Year of Diagnosis:

RESPITE CARE GRANT PROGRAM

Care Partner Information:

Full Name:		
Relationship to Person with Parkinson's:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

Additional Questions:

- Is the person with Parkinson's disease or the care-partner eligible for reimbursement for the same service from another source? (Circle One) **YES / NO**
- Is the person with Parkinson's disease a resident of a care facility, such as a personal care home, assisted living facility, or nursing home? (Circle One) **YES / NO**

Verification of Information and Release From Liability:

I (caregiver), _____, verify that the information provided in this application is accurate as of this date to the best of my knowledge. I understand and agree that the role of the RPN Respite Care Grant Program is that of an intermediary, with the sole purpose of providing financial assistance for the purchase or provision of respite care. I understand and agree that RPN assumes no liability or obligation to provide or manage the above stated services, and takes no responsibility for the respite care provider's quality of care.

Signature

Date

Respite Care Program Diagnosis Statement

The following patient is being considered for funds from Rochester Parkinson Network's Respite Care Program. In order to qualify for these funds, the individual must be diagnosed with Parkinson's Disease, verified by an attending physician, or qualified nurse or social worker. Thank you for your assistance!

Patient Information:

Name: _____

Date of Birth: _____

Diagnosis: _____

I (qualified medical professional), _____,
do hereby certify that the information contained herein is correct to the best
of my knowledge.

Signature of Physician/Nurse/Social Worker Date

Office Address

Office Phone Number(s)