

American Parkinson Disease Association Information and Referral Center

Emory University School of Medicine • 1841 Clifton Road N.E., Room 504 • Atlanta, Georgia 30329
Tel 404.728.6552 • Fax 404.728.6865

Jorge L. Juncos M.D.
Director

Mary Louise M. Weeks, R.N., B.S.N.
Coordinator

RESPIRE CARE ASSISTANCE PROGRAM APPLICATION FORM

Type of Program You Are Applying for: _____ In Home Respite

CLIENT/PERSON WITH PARKINSON'S DISEASE

AGE

NAME OF SPOUSE/CAREGIVER

RELATIONSHIP TO PERSON WITH PD

ADDRESS

APT # (IF APPLICABLE)

CITY

ZIP

HOME PHONE #

NAME OF CLIENT'S NEUROLOGIST

PHONE #

NAME OF CLIENT'S PRIMARY PHYSICIAN

PHONE #

ARE YOU RECEIVING ANY OTHER FUNDED OR SUBSIDIZED RESPITE CARE/HOMECARE SERVICES SUCH AS CCSP, SOURCE OR ANY OTHER TYPE FUNDING?

() YES () NO IF YES, WHAT KIND OF SERVICES? _____

IS THE CLIENT A VETERAN? ___ YES ___ NO IF YES, DOES HE/SHE RECEIVE AID AND ATTENDANCE FROM THE VA? ___ YES ___ NO

CLIENT'S YEARLY INCOME – based on last years' income tax form

\$ _____

You must include the front page of your tax return. If you do not submit a tax return, include copies of any income received including Social Security when returning the application.

If you have any special financial circumstances affecting your ability to pay a fair share of costs please explain in the space below.

CLIENT CONSENT

I understand, and agree, that in order to participate in the APDA Georgia Chapter Respite Care Program, it will be necessary to release information found on this application to the agency that provides these services. I understand that I must maintain annual membership in the APDA Georgia Chapter of \$20.00 in order to participate in the program. I further understand that the copy of my tax return, Social Security or other financial information sent in with this application will be shredded upon receipt by the APDA Information & Referral Center at Emory University, and will not be shared with anyone, or retained on file.

Client Signature: _____ Date: _____

COSTS FOR THE SERVICES

I understand that the APDA Georgia Chapter contracts with local agencies for the above services and that I may be responsible for sharing the cost at the level determined by my income. I understand and agree to pay my share of the costs for these services directly to the contracted agency. Further, any additional hours over the approved amount will become my sole responsibility.

Client Signature: _____ Date: _____

RELEASE OF LIABILITY

I understand that the APDA Georgia Chapter assumes no liability or obligation for the above stated services or responsibility for the performance or failure of services provided by the contracted agencies, whether direct or indirect.

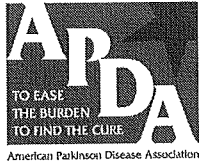
Client Signature: _____ Date: _____

PLEASE RETURN:

- I. Completed and Signed Application Form
- II. Neurologist Order – Confirming:
 1. Primary Diagnosis of Parkinson's disease
 2. Type of care assistance needed
- III. Copy of first page of client's Tax Return from last year (black out social security numbers) or Copy of Social Security Statement
- IV. Membership donation (\$20.00) if not already a member

MAIL TO:

AMERICAN PARKINSON DISEASE ASSOCIATION
Information & Referral Center
Attn: Mary Louise Weeks, RN, BSN
1841 Clifton Road NE
Room 504
Atlanta, GA 30329



AMERICAN PARKINSON DISEASE ASSOCIATION
GEORGIA CHAPTER
RESPITE CARE ASSISTANCE PROGRAM

PROGRAM OVERVIEW

The Georgia Chapter of the American Parkinson Disease Association (APDA) having long recognized the need for caregiver respite in the Parkinson's Community, implemented an In-Home Respite Care Program in 1998 in the metro Atlanta area and expanded in 2007 to include all of Georgia.

Respite care can be defined as a short-term option to provide periodic time off for the full-time family caregiver (care partner) to rest and renew him/her from providing continuous assistance to a family member with a diagnosis of Parkinson's disease. Qualification process for these programs includes completing an application, obtaining a physician's order confirming the diagnosis of Parkinson's disease and the need for care assistance, submission of income guidelines and annual membership to the Georgia Chapter of APDA.

HOW IT WORKS

As a service to the Parkinson's community, the Georgia Chapter of APDA will pay in its entirety or subsidize the cost of the program, dependent on eligibility and income. Care recipients must adhere to Respite Care Guidelines in order to be eligible for the program on a first need, first serve basis, subject to fund availability and prioritized by client income.

In Home Program: The patient and the caregiver must reside together and be a member of the Georgia Chapter of the APDA. The patient should essentially be house bound. Non-medical services are provided through a licensed home care agency with bonded and insured workers. In-home respite services may offer assistance with activities of daily living (ADL) and companion services. ADL assistance includes bathing, dressing, toileting as well as light meal preparation and light housekeeping directly related to assisting the individual with Parkinson's disease.

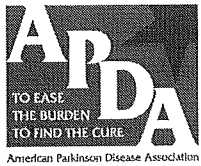
The Georgia Chapter of APDA will pay or subsidize the cost of up to 7 hours a month of non-medical home care services through our preferred home care agency's fee for approved applicants. With the Chapter sharing the cost, help is attainable at an affordable rate. General costs for home care services range from \$16.00 to \$18.00/hour.

Income Guidelines and Estimate of Shared Costs:

\$0 - \$30,000	APDA pays the cost	Client pays: nothing
\$30,001 - \$55,000	APDA pays 75% of cost	Client pays: \$3.50/hour
\$55,001 - above	APDA pays 50% of cost	Client pays: \$7.00/hour

HOW TO APPLY

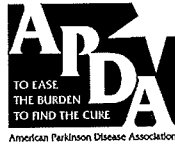
The applicant must contact the APDA Information and Referral Center at Emory University, 404-728-6552 and request an application for respite services.



**AMERICAN PARKINSON DISEASE ASSOCIATION
GEORGIA CHAPTER
RESPIRE CARE ASSISTANCE PROGRAM**

PROGRAM GUIDELINES

- **The care partner (giver) must reside in the home of the Parkinson's care recipient and be responsible for providing continuous non-professional care.**
- **The patient should be essentially house bound.**
- **The care recipient may not be receiving any other funded or subsidized respite care or homecare services such as Medicaid or Veteran's Aid and Attendance.**
- **To be considered for the program, the care recipient's physician must confirm the diagnosis of Parkinson's disease and list the impairments that necessitate supervision.**
- **In order to qualify for the respite program, the care recipient must be a current member of the Georgia Chapter of the American Parkinson Disease Association. Membership is \$20.00 a year.**
- **The respite care approval process may take 7-10 days from receipt of the application.**
- **Once approved for in home respite care, a referral will be made to the preferred Home Care Agency (HCA).**
- **The HCA will then contact the care partner, set up an initial assessment and arrange services.**
- **The care recipient must be willing to sign and adhere to the service provider's client service agreement and be prepared to pay their share of the hourly cost per visit.**
- **Funding requests will be reviewed in the order in which they are received.**
- **APDA Respite Care Programs are offered pending fund availability with services prioritized based on client and care partner annual income.**
- **Special requests and special circumstances will be reviewed on an individual basis by Georgia Chapter's respite care committee.**
- **Each client is signed up for one year pending fund availability and will be reassessed annually.**



**Georgia Chapter American Parkinson Disease Association
2009 – 2010 Membership Application/Renewal**

***Our Chapter Depends On Your Annual Membership Dues
And Donations To Help Support The Chapter Activities.***

The Georgia chapter fiscal year begins September 1st and ends August 31st. The annual membership fee is \$20.00.
Please fill out the information below, make checks payable to Georgia Chapter APDA:

APDA Georgia Chapter, P.O. Box 49416, Atlanta, GA 30359

New Member: _____ Renewing member: _____

Please Print:

Date: _____ What support group do you belong to: _____

Last Name: _____ First Name: _____ Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ E-Mail address: _____@_____

We understand that some individuals cannot afford to pay the full cost of membership dues. What membership amount would be reasonable for you to pay? \$ _____

If you are making an additional donation at this time, please check one of the following:

In Honor/Memory of _____

General Operating Support

Respite Program

If you no longer wish to receive mail from the Georgia Chapter APDA, please check this box ,
complete the name and address fields above and return the form to the above address.

Georgia Chapter APDA
www.apdageorgia.org
404-325-2020

Information and Referral Center • Quarterly newsletter • Support groups • Monthly educational meetings
Free educational material • Caregiver Symposium • Respite Care Program/Parkinson Alzheimer's Caregiver Time Out Program