

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 Northwest 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:** Covers 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, 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:** Covers 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:** Covers 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, email, or fax the completed application along with required documentation to: APDA Northwest Chapter
180 Nickerson Street, Suite 108
Seattle, WA 98109
Email to: apdanw@apdaparkinson.org
Fax: 206-455-8980

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 and/or information and referrals to services in the community, or questions about APDA fundraising events, education programs or volunteer opportunities, please contact APDA Northwest at 206-695-2905.

Applicant and Care Partner Information

("Applicant" has Parkinson's disease diagnosis)

Total Amount Requested: \$ _____

Up to \$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
- Medication
- Respite/Adult Day Program
- Assistance at Home
- Transportation
- Childcare
- Adaptive Equipment

APPLICANT Full Name: _____

Applicant Date of Birth _____ Year of PD 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 signature on previous paperwork submitted for APDA Ride Repay, Caregiver's Day Off, or Patient Aid Scholarship Program, then the Physician Confirmation section can be left BLANK.

Physician Confirmation:

The above-named applicant is currently under my care and has a diagnosis of Parkinson's disease.

Physician Name (please print): _____

Healthcare Institution: _____

Email: _____ 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.
- Understand this program is intended for individuals with PD in need of financial assistance.
- Reside within the APDA Northwest region of Washington, Idaho, Alaska, Montana or Oregon.
- Resides in the community, not in a rehabilitation center or long-term care or skilled nursing facility.
- Agree to be on the APDA Northwest 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 Northwest within the year that the scholarship was issued for the purpose this scholarship was intended to be used (no later than Dec 31).

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.

Date:

Applicant Signature

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

Date:

Care Partner Signature (if applicable)

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.](#)

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