AMERICAN PARKINSON DISEASE ASSOCIATION
Strength in optimism. Hope in progress.

COVID-19 Patient Assistance Program

Application Information and Instructions

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.

COVID-19 Assistance: APDA has received grant funding to provide aid to people with Parkinson's Disease who need additional support due to the COVID-19 crisis. A cash grant of up to $250 can be requested to support the cost of food, utility bills, and rent/lodging, as described below. Funds are limited and will be awarded on a first come basis. In order to qualify for the program, the applicant must have a diagnosis of Parkinson's disease and provide proof of that diagnosis.

- **Cost of Food**: Supports expenses for groceries/restaurant takeout and delivery.
- **Utility Bills**: Assistance in paying for utilities in the home, such as electric, water, gas, oil, etc.
- **Lodging**: Supports expenses related to paying for rent or mortgage.

To qualify for the COVID-19 Assistance Program, the applicant agrees to the following:

1. The guidelines and requirements of this Patient Assistance Program and requests financial assistance from APDA.
2. Provide confirmation of a diagnosis of Parkinson's Disease or Parkinsonism.
3. Resides in the community, not in a rehabilitation center or long-term care or skilled nursing facility.
4. That any additional expenses beyond the approved amount will be the applicant's sole responsibility.
5. 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.
6. If requested, will provide copies of receipts/invoices to APDA for the purpose this grant is intended to be used.

Instructions:

1. Complete Patient Assistance COVID-19 Application.
   - Mail or email the completed application along with required documentation:
     American Parkinson Disease Association
     Attn: Emily Ciorciari
     135 Parkinson Ave.
     Staten Island, NY 10305
   - Or email the completed application to: Emily Ciorciari eciorciari@apdaparkinson.org
2. Applications will be reviewed on a first come basis and are based on availability of funds. The program is subject to change or discontinuation without further notice once funds are exhausted.

For information about Parkinson's disease and/or information and referrals to services in the community, please contact APDA at apdaparkinson.org/community/ or call the toll free helpline 800-223-2732.

Support for this program was provided by a generous grant from: Adira Foundation Genentech A Member of the Roche Group

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Application

Applicant Full Name: ______________________________ **DOB**: _________ **Year of Diagnosis**: ______________

Care Partner Full Name (if applicable): ____

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

Diagnosis Confirmation:
I am currently under the care of my physician and have 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 ➔**

If a physician stamp or letter is not available:
☐ I agree that by providing the name and contact information of my physician, I confirm I have a diagnosis of Parkinson's Disease or Parkinsonism and agree my physician can be contacted to verify your diagnosis if necessary.

Total Amount Requested: $ __________ (INSERT AMOUNT) *NO MORE THAN $250 one-time payment can be awarded.*

This grant is intended to be used for the following (check all that apply):
☐ Food/Groceries ☐ Utilities ☐ Lodging/Rent/Mortgage

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.

I have agreed to submit this application electronically and by typing my name, I certify under penalty of perjury and false swearing that my answers are correct to the best of my knowledge.

_______________________________________ _____________________
Applicant's Signature Date

_______________________________________ _____________________
Care Partner Signature (if applicable) Date

FOR APDA USE ONLY:
Date received: ________________ Date approved: ________________ Amount Approved: $ ________________
All application requirements received: ☐ Yes ☐ No Date scholarship payment was issued: ________________

Support for this program was provided by a generous grant from: