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

Financial Support Program Application

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 Chapter is pleased to offer a Financial Support Program that provides financial assistance to people with Parkinson's disease (PD) and their families. Approved applicants will be granted $300 once per calendar year (January-December). Funds may be used for programs, services and/or activities designed to improve quality of life.

Applications are reviewed on a rolling basis and applicants will be notified within sixty (60) days of receipt. Awards are made on a first-come basis and are based on the availability of funds. The program is subject to change or discontinuation with limited notice.

Eligibility Guidelines:

To qualify for this Financial Support Program, the applicant will:

- Complete and submit the entire application.
- Attest to having a diagnosis of Parkinson's disease or Parkinsonism.
- Understand this program is intended to support persons with Parkinson's disease in need of financial assistance.
- Reside within the APDA Northwest Chapter area which is WA, OR, ID, MT, and AK.
- Reside in the community, not in a rehabilitation center or long-term care, skilled nursing facility.

Instructions:

1. Complete the Financial Support Program Application
2. Mail or email the completed application to:

   APDA Northwest Chapter
   180 Nickerson Street, Suite 108
   Seattle, WA 98109
   apdanw@apdaparkinson.org

Questions? Contact us at apdanw@apdaparkinson.org or (206) 695-2905.

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Applicant and Care Partner Information
("Applicant" is the person diagnosed with Parkinson's disease or Parkinsonism)

Applicant Full Name: _____
☐Check if applicant is the Primary Contact

Year of Diagnosis: _____

Birth Date: _____

Care Partner Full Name (if applicable): _____
☐Check if the Care Partner is the Primary Contact

Care Partner Relationship to Applicant: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Applicant _____ Care Partner _____

Email: Applicant _____ Care Partner _____

Total Amount Requested: $ _____
(Up to a $300 one-time payment per calendar year can be awarded (January-December)

Have you applied for this program or any other related financial award from APDA in previous years? ☐ No ☐ Yes

How did you hear about the Financial Support Program?

_____

_____

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Applicant 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, services and/or activities this program 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.

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 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.

Signature:

My signature below indicates I have read and understood the eligibility and terms outlined above and confirm the applicant has a diagnosis of Parkinson's disease or Parkinsonism.

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

Applicant's Signature — Date: Click here to enter a date.

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

Care Partner Signature (if applicable) — Date: Click here to enter a date.

FOR APDA USE ONLY:

Date received: Click here to enter a date.
Date approved: Click here to enter a date.
Amount Approved: $
Date payment was issued: Click here to enter a date.

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