Parkinson Network of Mt. Diablo

PNMD Flying Solo Assistance Program Application

Date: _____

Person with Parkinson's (PwP) name:

_____

Email address: _____

Home phone: _____

Cell phone: _____

Street address: _____

City: _____

State: _____

CP Zip:_____

Process: This application is for an annual grant of home health care services through a local Caregiver Resource Center (CRC) or a licensed In-home Service Provider/Agency. The grant is for $1200 (includes the Agency's administration fee), and it must be used within 12 months of the award date. See Flying Solo Program Application Process available on the PNMD website or request an email copy from flyingsolo@pnmd.net.

You may complete documentation at pnmd.net or submit documentation to:
Parkinson Network of Mt. Diablo, PO Box 3127, Walnut Creek, CA 94598; or respitecare@pnmd.net.

1. Please certify by initialing below that you have Parkinson's Disease (or affiliated disease as defined by the Parkinson's Foundation).

   "I (Person with Parkinson's) so certify." Please initial here: _____

2. Please certify by initialing below that you are currently receiving minimal care assistance from outside resources.

   "I (Person with Parkinson's) am solely responsible for my own self-care.

   Please initial here: _____

3. Please certify by initialing below that you have read and agree to the stipulations in the Flying Solo Care Program Application Process document.

   "I (Person with Parkinson's) so certify." Please initial here: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. If this application leads to a grant, I understand that false or misleading information in my application may result in denial or loss of funding.
Signature: _____

Date: _____