Parkinson Network of Mt. Diablo

PNMD Respite Grant Application

Date: _____

Person with Parkinson's (PwP) name:

_____

Care partner's (CP) name: _____

Relationship to PwP: _____

CP Email address: _____

CP Home phone: _____

CP Cell phone: _____

CP Street address: _____

CP City: _____

CP State: _____

CP Zip:_____

Process: This application is for an annual grant of respite 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 Respite Care Program Application Process available on the PNMD website or request an email copy from respitecare@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 are the legally authorized designated caregiver of the PwP who has Parkinson's Disease (or affiliated disease as defined by the Parkinson's Foundation).

   "I (Care partner) so certify." Please initial here: _____

2. Please certify by initialing below that you are not receiving Medicaid funding for care.

   "I (Care partner) am not receiving funding from the Federal, State or County government for in-home support services." Please initial here: _____

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

   "I (Care partner) so certify." Please initial here: _____

4. Complete the Zarit Caregiver Burden Assessment survey online or provide a completed survey via email or regular mail.

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.
Care partner signature: _____

Date: _____