

## **MAINE PARKINSON SOCIETY RESPITE CARE APPLICATION**

The Maine Parkinson Society (MEPS) sponsors the Respite Care Program for patients and their families throughout the state of Maine.

Specialized training *Set It in Motion* © is available to any Health Care Provider, to ensure quality Parkinson's disease trained workers who provide companionship and personal care for the Parkinson's patients.

The information on this sheet is necessary to determine the client's eligibility for Respite Care services. Your personal information is strictly confidential and will be shared with no outside parties.

Please complete this form and mail or fax a copy to;

**Maine Parkinson Society**  
**5 Bucknam Road, Suite 1A**  
**Falmouth, ME 04105**

**Or Fax Completed Form to:**  
**207-781-1546.**

**CLIENT/CARE GIVER INFORMATION**

Client's Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Caregiver's Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Client Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Area of Maine County: \_\_\_\_\_

**CLIENT LOCATION**

Nearest Cross Street: \_\_\_\_\_

Directions: \_\_\_\_\_

\_\_\_\_\_

**CLIENT PERSONAL DATA**

Male: \_\_\_\_ Female: \_\_\_\_ Age: \_\_\_\_ Number of Household Members: \_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Physician's Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Primary Language: \_\_\_\_\_

Marital Status: \_\_M \_\_S \_\_D \_\_W

Special Circumstances

\_\_\_\_\_

\_\_\_\_\_

## CLIENT CONSENT

I understand and agree that in order to participate in the Home Respite Program of the Maine Parkinson Society; it will be necessary for MEPS to release information found on this application to the Health Care Agencies that provide these services.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## COSTS FOR THE SERVICES

I understand that the Maine Parkinson Society will reimburse for 50% of client paid services to a certified Health Care Agency to provide respite care services. I understand and agree to pay my share of costs for these services as determined by MEPS. Further, any additional hours, over the approved amount and not to exceed \$500. per care recipient per year, will become my (client) sole responsibility.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## RELEASE OF LIABILITY

I understand that the Maine Parkinson Society assumes no liability, is obligation to provide the above stated services, or responsible for the failure of Respite Care giver performance, whether direct or indirect.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### AGENCY USE ONLY

Respite Provider: \_\_\_\_\_ Date of Training \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Provider Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: 207- \_\_\_\_\_ - \_\_\_\_\_

Client Cost/Reimbursement: \$ \_\_\_\_\_ Attach Client Paid Receipts \_\_\_\_\_

Approved \_\_\_\_\_