Maine Parkinson Society
Respite Care Application
359 Perry Road, Bangor, ME 04401
Tel (800) 832-4116 or Fax (207) 262-9908

Maine Parkinson Society (MEPS), recognizing the need for respite care in the Parkinson community, raises funds to provide respite care for caregivers of individuals with Parkinson's disease living in the State of Maine. Please complete this Respite Care Application and return this completed form to: Maine Parkinson Society, 359 Perry Road, Bangor, ME 04401, ATTN BOARD OF DIRECTORS,

Client's Name: _____

Address: _____

City: _____State _____ Zip: _____

Telephone _____Cell phone_____

Email Address_____

Client Personal Data:

Male ____ Female ___ Age ___ Date of Birth Month ____ /Date _____ / Year ____

Primary Language: _____

Marital Status: (Circle One) Married Single Divorced Widowed

Number of Household Members: ____

Primary Physician's Name: _____Telephone: _____

Name and signature of Neurologist, confirming that you have Parkinson's disease.

(Signature)_____ Date Signed: _____

(Printed Name)_____ Year of diagnosis: _____

1. Client Consent

I understand and agree that in order to participate in the Respite Reimbursement 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: _____

2. Release of Liability

I understand and agree that the Maine Parkinson Society assumes no liability or obligation to provide the above stated services, and takes no responsibility for the respite provider's quality of care.

Client signature: _____ Date: _____

3. Reimbursement/payment for services:

- The program will pay either:
  A. An invoice sent from the approved provider, or
  B. Reimbursement to the patient/caregiver upon proof of payment to an approved provider.
- Respite care payment is contingent on funding availability.
- Respite care payments are available up to a fixed amount annually.

Client signature: _____ Date: _____

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Client's Name: ____

1. **Name of Corporate approved respite care provider to be used by patient**:

   ____

   Contact Person: ____

   Provider Address**:** ____

   City: ______________________________ State: __________Zip: ____________

   Telephone ___________________________ Cell Phone ______________________

   Email Address____

2. **Name of Non-Corporate approved respite care provider to be used by patient**:

   ____

   Contact Person: ____

   Provider Address**:** ____

   City: ____________________________________ State: __________Zip: _________

   Telephone ________________________________ Cell Telephone _______________

   Email Address____

   What is the family member's relation to client? _________________________________

3. If you would like to tell us of any special circumstances, or to express an urgency of need, please write below or attach a separate sheet.

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MEPS USE ONLY

Case Number: ______________________________ Date Received: ____________________

Respite Provider: ____________________________ Date of Training: __________________

Contact Person: _____________________________ Tel. ____________________________

Provider Address: ____________________________ City: _________________ Zip: _______

Date Approved: _______________ Client Contacted: ___________

Notes: