

Parkinson's Resources

Home Care Reimbursement Program

The Home Care Reimbursement Program is designed to provide modest financial assistance for the care of people with Parkinson's who require assistance with activities of daily living. This service is available to households in the PRO service area who express that economic hardship is a barrier to obtaining needed services. Eligible applicants may include the family caregiver of a person with Parkinson's or a person with Parkinson's who lives alone.

Please complete the application and submit to:

Mail:

Parkinson's Resources of Oregon
Attn: Home Care Reimbursement Program
8880 SW Nimbus Ave., Suite B,
Beaverton, OR 97008

E-mail:

Info@Parkinsonsresources.org

Please review the qualifications and guidelines below to make sure you understand the program and meet eligibility requirements before submitting the application. If you have questions, please call PRO at (800) 426-6806 and ask to speak with our social worker.

- ✓ The applicant lives in Oregon or SW Washington.
- ✓ The applicant is receiving care at home (not Assisted Living, etc.).
- ✓ The person with Parkinson's disease requires assistance with Activities of Daily Living (ADLs and IADLs). Verification of diagnosis may be required.
- ✓ If the applicant is a family member, they must be the primary caregiver. Can include spouse, domestic partner, or adult child living with the person with Parkinson's.
- ✓ The financial situation creates a barrier to obtaining caregiver services. (There is an expressed need or hardship.)
- ✓ Funds must be used for the care of the person with Parkinson's. If you have questions about eligibility of expenses, please contact PRO.
- ✓ This is a REIMBURSEMENT program. Payment will be made directly to the approved applicant, not the service provider. Payment will be made for services provided after a signed agreement is in place and upon submission of official service receipts.
- ✓ Only one grant request per year will be considered for each household. A maximum of two awards will be made, and preference will be given to first-time applicants. The number of grants that may be awarded is limited by the amount of funding available.
- ✓ Funds awarded must be used within 12 months.

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I am applying as a (please circle one)

Person with Parkinson's (PwP)

Family Caregiver

About the Applicant:

First Name _____ Last Name _____

Relationship to PwP (self, spouse, adult child, etc.) _____

Phone Number _____ E-mail Address _____

Street Address _____

City _____ State _____ Zip _____

About the PwP:

Year of PD diagnosis _____ Current Age _____

Current Neurologist _____

Does the Person with Parkinson's receive Medicaid for in-home care? __Yes __No

How often does the person with PD need assistance with the following activities?

Preparing Meals	Never	Sometimes	Always
Grocery Shopping	Never	Sometimes	Always
Eating Meals	Never	Sometimes	Always
Dressing	Never	Sometimes	Always
Bathing & Personal Hygiene	Never	Sometimes	Always
Mobility & Transfers	Never	Sometimes	Always
Transportation	Never	Sometimes	Always
Medication Management	Never	Sometimes	Always
Financial Management	Never	Sometimes	Always

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Additional Information

What are some daily challenges that you would like assistance with?

How would you describe your current level of social interaction with others?

Who is in your support network? Do they currently help with any daily needs?

What sources of support and assistance have you explored, and what was the outcome?

Have you noticed any Parkinson's-related cognitive changes that make your daily life more challenging? Some examples might be challenges with decision-making, motivation to carry out tasks, and memory changes.

What is the financial situation that makes it challenging to obtain more care?

Is there anything else you'd like us to know?

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Agreement

If I am approved for this program, I understand the following:

1. I agree to work with the PRO social worker to assess my situation, develop a service plan, and pursue additional sources of support.
2. Reimbursement under this program occurs after a service plan is in place and upon submission of verifiable receipts.
3. My signature on the application is a testament to my financial need.

Signature of Applicant _____

Date of Application _____

Signature of PRO Representative _____

Date of Approval _____

Process:

- Completion and submission of application.
- Telephone screening with PRO social worker.
- Applicant will be notified within 2 weeks from the date of completed intake process.
- If approved, applicant will work with the social worker to develop a care plan and commence services.
- An award letter and reimbursement forms will be sent by mail upon approval.

Please review this application to ensure that all sections are filled out completely. Any incomplete sections may cause delay in the processing of your request.