UNLOCKING THE SECRETS OF BRAIN DISEASE®

April 2025

The CurePSP Quality of Life Respite Grant was established to provide support for hiring in-home respite care services for those living with or caring for someone diagnosed with progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy. The fund provides a one-time grant for 100 hours of in-home care services (up to $35/hr) by a home care agency chosen by the awardee. You will not need to pay directly; the home care agency will be paid directly by CurePSP.

Eligibility:

- Individuals and care partners living with a clinical diagnosis of PSP, CBD or MSA anywhere in the United States
- The person with PSP, CBD or MSA is cared for at home (not in a long-term care facility)
- Has not been a recipient of a CurePSP Quality of Life Respite Grant in the past
- Is not receiving more than 15 hours per week of professional respite care services (i.e. adult day care, in-home care)
- Has a combined annual income of less than $90K and does not have long-term care insurance

Grants are awarded on a quarterly basis and the deadlines are as follows: January 31, April 30, July 31 and October 31. Due to ongoing updates to the grant program, please make sure that the application you are submitting corresponds with the correct quarter.

You may mail, fax or email questions or completed applications to Joanna Teters at:

CurePSP
ATTN: Joanna Teters
325 Hudson Street, Floor 4
New York, NY 10013

Office: 347-294-2871
Fax: 410-785-7009
E-mail: teters@curepsp.org

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Patient and Care Partner Information

April 2025

* 1. Name of person living with PSP/CBD/MSA

Name	
Address	
Address 2	
City	
State	
ZIP	
Email Address (if applicable)	
Phone Number	

* 2. Date of birth of person living with PSP/CBD/MSA (MM/DD/YYYY)

* 3. Gender of person living with PSP/CBD/MSA

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to respond

* 4. Race/ethnicity of person living with PSP/CBD/MSA

- [ ] Asian
- [ ] Black or African American
- [ ] Hawaiian or Other Pacific Islander
- [ ] Native American, Indigenous, or Alaska Native
- [ ] White
- [ ] Prefer not to respond
- [ ] Other (please specify)

* 5. Is the person living with PSP/CBD/MSA of Hispanic or Latino origin?

- [ ] Yes
- [ ] No
- [ ] Prefer not to respond

* 6. Marital status of person living with PSP/CBD/MSA

- ◯ Single
- ◯ Married
- ◯ In a relationship
- ◯ Widowed

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* 7. What is the relationship of the primary family care partner to the individual with PSP/CBD/MSA?

Note: if the person applying does not have a primary family care partner and/or is currently only receiving care from a home care professional, please select "none of the above"

- ◯ Spouse/partner
- ◯ Adult child
- ◯ Friend
- ◯ Other (please specify)

  [ ]
- ◯ None of the above (this individual lives alone and does not have a clearly identified primary family care partner)

* 8. Approximately how many hours per day is the person living with PSP/CBD/MSA receiving direct care from their primary family care partner?

[ ]

* 9. Does the primary family care partner live with the person diagnosed?

- ◯ Yes, the primary family care partner lives with the patient
- ◯ No, the primary family care partner does not live with the patient

* 10. Primary family care partner's contact information:

Name

Address

Address 2

City

State

ZIP

Email Address

Phone Number

* 11. Primary family care partner date of birth (MM/DD/YYY)

* 12. Gender of primary family care partner:

- Male
- Female
- Non-binary
- Prefer not to respond

* 13. Is the primary family care partner currently working?

- Part-time
- Full-time
- No, not currently working

* 14. Is there anybody else who is involved in the care or support of the person living with PSP/CBD/MSA? If yes, please list out who and what their level of involvement is:

* 15. Relationship of applicant to person living with PSP/CBD/MSA?

- ◯ I am the patient
- ◯ Spouse/Partner
- ◯ Child
- ◯ Friend
- ◯ Healthcare Professional
- ◯ Other (please specify)

16. Contact information of the applicant (if different from the contact information of the patient or primary family care partner listed earlier in this application)

Name	
Organization/medical institution (if applicable)	
Address	
Address 2	
City	
State	-- select state --
ZIP	
Email Address	
Phone Number	

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Finances & Insurance

January 2025

* 17. Which of these best describes the combined household income for the person living with PSP/CBD/MSA from the past year?

- ◯ Under $30,000
- ◯ Between $31,000-$60,000
- ◯ Between $61,000- $90,000
- ◯ Over $91,000

* 18. What type of health insurance does the person living with PSP/CBD/MSA have?

	Yes	No
Medicare (original + supplemental plan or Medicare advantage plan)	◯	◯
Medicaid	◯	◯
Veteran's Benefits	◯	◯
Private Insurance	◯	◯

Other (please specify)

* 19. Does the person living with PSP/CBD/MSA have long-term care insurance?

- ◯ Yes
- ◯ No

* 20. If the person living with PSP/CBD/MSA does have long-term care insurance, are they currently using it to pay for professional care services?

- ◯ Yes
- ◯ No
- ◯ N/A - patient does not have long-term care insurance

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Patient History and Current Care Needs

January 2025

* 21. What is the person's diagnosis?

- [ ] Progressive supranuclear palsy (PSP)
- [ ] Corticobasal degeneration or corticobasal syndrome (CBD/CBS)
- [ ] Multiple system atrophy (MSA)
- [ ] Other (please specify)

* 22. What year did the person begin exhibiting symptoms?

* 23. What year was the person diagnosed with PSP/CBD/MSA?

* 24. If the person living with PSP/CBD/MSA has any other medical conditions, please list here:

* 25. What areas of daily living does the person living with PSP/CBD/MSA need assistance with?

Please check all that apply:

- [ ] Showering/bathing
- [ ] Toileting
- [ ] Dressing
- [ ] Eating
- [ ] Ambulation/mobility
- [ ] Other (please specify)

* 26. Which activities or tasks could the person living with PSP/CBD/MSA and/or their family/care partner benefit from assistance with? Please check all that apply:

- [ ] Cooking/preparing meals
- [ ] Household tasks/cleaning
- [ ] Grocery shopping/errands
- [ ] Medication reminders
- [ ] Transportation (to appointments, etc.)
- [ ] Companionship/activity engagement/socialization
- [ ] Supervision/monitoring due to cognitive decline and/or falls risk
- [ ] Care partner respite
- [ ] Other (please specify)

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Network of Care

* 27. Is the person living with PSP/CBD/MSA currently receiving professional care services? (This does not include PT/OT/SLP)

Please check all that apply:

- [ ] In-home care
- [ ] Adult day care
- [ ] Skilled nursing care
- [ ] Other (please specify)
- [ ] None of the above

* 28. If the person living with PSP/CBD/MSA is currently receiving professional care services, how many hours per week? (adult day care, in-home care, etc.) Please be specific.

* 29. Is the person living with PSP/CBD/MSA currently receiving hospice services?

- ◯ Yes
- ◯ No

* 30. In the past, has the person living with PSP/CBD/MSA received this CurePSP respite grant?

- ◯ No
- ◯ Yes (please note month/year the grant was received)

* 31. Has the person living with PSP/CBD/MSA ever received any other respite grants or vouchers?

- ◯ No
- ◯ Yes (please specify)

* 32. How did you hear about this grant program?

- ◯ Friend or family
- ◯ CurePSP website
- ◯ CurePSP peer supporter or volunteer
- ◯ Local support group
- ◯ Physician or healthcare professional
- ◯ Social media
- ◯ Other (please specify)

* 33. Narrative - In a few sentences or a short paragraph, please tell us:

1. how the person living with PSP/CBD/MSA and/or their family plans to use this grant
2. how the person living with PSP/CBD/MSA and/or their primary family care partner (e.g. emotional/physical health, stress) has been impacted by the PSP/CBD/MSA diagnosis and journey
3. and how receiving this grant would positively impact daily quality of life and care.

Please also use this space to share anything else you would like us to consider while reviewing your grant application.

Note: Please provide a full narrative of your experience and current situation. One-sentence and one-word answers do not give the review committee a full understanding of your situation. If one or two-sentence answers are provided, your application will likely not advance in the review process. Please provide as much detail as you can so that we can learn more about you and your loved one. Be sure to review your information for accuracy before submitting your application.

Physician Diagnosis Verification Form

Physician's name	
Name of medical practice/clinic	
City, State	
Phone	
Specialty	☐ General Neurology ☐ Movement Disorder ☐ Specialist Memory Disorder ☐ Primary Care ☐ Other

Name of patient	
DOB (MM/DD/YYYY)	
Diagnosis	PSP ☐ CBD ☐ MSA ☐ Other: _____

By my signature I verify to the best of my knowledge that the patient above has a diagnosis of PSP/CBD/MSA

Physician Name (Print)	
Signature	
Date	