curePSP®
UNLOCKING THE SECRETS OF BRAIN DISEASE®

THE CHERIE LEVIEN QUALITY OF LIFE FUND

Administered by CurePSP

APPLICATION FORM

Please have Carepartner fill out this information for the Patient

Date: _____

Name of Patient: _____

Address: _____

Phone: _____

Email: _____

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced or Separated ❑ Widowed

Age: _____

When do you think the Patient started having symptoms? _____

When was the Patient formally diagnosed with PSP? _____

Name of current physician treating the Patient for PSP:

Name: _____

Address: _____

Phone: _____

Specialty (*example, Neurologist*): _____

Did this physician provide the Patient with information regarding CurePSP? ❑ Yes ❑ No

Has the Patient been the primary wage earner? ❑ Yes ❑ No

Is the Patient currently working? ❑ Yes ❑ No

If yes, is the Patient working full or part-time? ❑ Full-time ❑ Part-time

Does the Patient receive any income not related to work? ❑ Yes ❑ No

If yes, please indicate all that apply:

- Social Security ❑ Yes ❑ No
- Social Security disability ❑ Yes ❑ No
- Pension ❑ Yes ❑ No
- Investments ❑ Yes ❑ No
- Family ❑ Yes ❑ No
- Other ❑ Yes ❑ No

  Please describe _____

  _____

Does the Patient currently have health insurance? ❑ Yes ❑ No

If yes, indicate all that apply:

- Medicare ❑ Yes ❑ No
- Medicaid (Medical Assistance) ❑ Yes ❑ No
- Veteran's coverage ❑ Yes ❑ No
- Commercial Insurance ❑ Yes ❑ No
- Other ❑ Yes ❑ No

  Please describe _____

  _____

Has the Carepartner been the primary wage earner? ❑ Yes ❑ No

Is the Carepartner currently working? ❑ Yes ❑ No

If yes, is the Carepartner working full or part-time? ❑ Full-time ❑ Part-time

Does the Carepartner receive any income not related to work? ❑ Yes ❑ No

If yes, please indicate all that apply:

- Social Security ❑ Yes ❑ No
- Social Security disability ❑ Yes ❑ No
- Pension ❑ Yes ❑ No
- Investments ❑ Yes ❑ No
- Family ❑ Yes ❑ No
- Other ❑ Yes ❑ No

Please describe _____

_____

If the Patient has any other medical conditions, please list:

_____

_____

_____

_____

Please rate the Patient's current ability to care for him or herself.

❑ Needs some assistance

❑ Needs daily assistance

❑ Needs daily and evening help

❑ Confined to bed

Narrative:

Please describe in 500 words or less (on a separate sheet) what you've done to try to secure respite services, why additional financial help is needed and what benefits you think will be a result of receiving these funds.

Please submit:

1. Application Form

2. Narrative

3. Physician Diagnosis Verification Form

Please send completed application via email, fax or regular mail to:

ATT: Joanna Teters
CurePSP
404 Fifth Avenue, 3rd Floor
New York, NY 10018
info@curepsp.org
Office: 443-578-5667
Fax: 410-785-7004

curePSP®
UNLOCKING THE SECRETS OF BRAIN DISEASE®

404 5th Avenue, 3rd Floor
New York, NY 10018
347-294-2873 (CURE)
www.curepsp.org
Facebook.com/curepsp.foundation

PHYSICIAN DIAGNOSIS VERIFICATION

Physician's Name: _____

Address: _____

Phone: _____

Specialty: _____

Name of Patient: _____

Address: _____

Phone: _____

By my signature I verify to the best of my knowledge that the Patient above has a diagnosis of PSP (Progressive Supranuclear Palsy).

_____

Print Name

_____

Signature

Date: _____