THE CHERIE LEVIEN QUALITY OF LIFE FUND

Administered by CurePSP

Application Form

Date:	
Name of person filling out this application	
Relationship to patient	
Address	
Phone	
E-mail	

Name of patient	
Address	
Phone	
E-mail	
Gender	male/female
Marital status (circle one)	single/married/divorced or separated/widowed
Date of birth	
Diagnosis (circle one)	PSP CBD MSA Other:

Main caregiver's name	
Relationship to patient	
Address	
Phone	
E-mail	
Gender (circle one)	male/female/prefer not to say

When do you think the **patient** started having symptoms?	
When was the **patient** formally diagnosed with PSP/MSA/CBD?	
Name of **current physician** treating the Patient for PSP/MSA/CBD?	name: address: phone: e-mail: specialty (for example: neurologist):
Did this **physician** provide the Patient with information regarding CurePSP?	

Has the **patient** been the primary wage earner?	yes/no
Is the **patient** currently working?	yes/no full time or 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 If other, 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 If other, please describe:

Has the **caregiver** been the primary wage earner?	yes/no
Is the **caregiver** currently working?	yes/no full time or part time
Does the **caregiver** 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 If other, 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

2. 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.

3. Submission

Please include in your application

1. the application form AND
2. the narrative AND
3. the physician diagnosis verification form (see next page).

Please check to see if you live within the Griswold Home Health Care service area by visiting their website www.griswoldhomecare.com or contact Griswold at 800-474-7965. They will help you to locate the closest office. If you do not live within 50 miles of a Griswold Office, please list three home care agencies that do service your local area (please list name of agency, location and contact phone number):

1.

2.

3.

Please send the completed application via e-mail, fax, or regular mail to:

CurePSP
Attn. Joanna Teters

Mailing address:	1216 Broadway; 2nd Floor
	New York, NY 10001
E-Mail:	teters@curepsp.org
Fax:	410-785-7009

PHYSICIAN DIAGNOSIS VERIFICATION

Physician's name	
Address	
Phone	
E-mail	
Specialty	

Name of patient	
DOB	

By my signature I verify to the best of my knowledge that the Patient above has a diagnosis of PSP/CBD/MSA **(PLEASE CIRCLE ONE)**

Print name	
Signature	
Date	