UNLOCKING THE SECRETS OF BRAIN DISEASE®

Cherie Levien Quality of Life Fund Application

The Cherie Levien Quality of Life Fund was created to provide respite for caregivers of persons living with prime of life neurodegenerative diseases including progressive supranuclear palsy, corticobasal degeneration and multiple system atrophy, while knowing that professional services are in place for their loved one. Research indicates that even temporary or intermittent relief of caregiving demands can help reduce stress and improve the quality of day-to-day life for family carepartners as well as for the person who is suffering with the disease.

The fund provides $1,500 grants for in-home care services by either our contracted provider Griswold Home Care, or a home care agency chosen by the awardee. You will not need to pay directly; Griswold or the agreed upon provider will be paid directly by CurePSP.

For any inquiries about the application or the fund, please contact Joanna Teters.

Proof of Diagnosis

Please be sure to attach a signed copy of the physician diagnosis verification form to this application. This form can be downloaded from www.curepsp.org/ineedsupport/respiteservices

Once completed, please fax, email or mail this form and the application to:

CurePSP
Attn: Joanna Teters
1216 Broadway, 2nd Floor
New York, NY 10001

Fax: 410-785-7009
Email: teters@curepsp.org
Phone: 347-294-2871

Deadlines

You may submit your application at any time, but the quarterly deadlines are as follows: January 30, April 30, July 30 and October 30. CurePSP will be in touch with you with a decision regarding your application approximately two weeks after the deadline has passed.

For more information about eligibility, FAQs, and re-application, please go to www.curepsp.org/ineedsupport/respiteservices

Patient and Carepartner Information

1. Contact information for patient (person diagnosed with PSP/CBD/MSA)

Name	
Address	
Address2	
City	
State	
PostalCode	
Country	
EmailAddress	
PhoneNumber	

2. Patient date of birth (MM/DD/YYYY)

3. Gender of patient

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

4. Race/ethnicity of patient

- [ ] 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 patient of Hispanic or Latino origin?

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

6. Marital status of patient

- ◯ Single
- ◯ Married
- ◯ In a relationship, not married
- ◯ Widowed
- ◯ Prefer not to respond

7. Is the patient currently receiving care from a primary family carepartner?

- [ ] Yes, the patient is receiving care from a primary family carepartner
- [ ] No, the patient is not currently receiving care from a primary family carepartner

8. Primary family carepartner's contact information:

Name	
Address	
Address 2	
City	
State	
Postal Code	
Country	
Email Address	
Phone Number	

9. Primary family carepartner's date of birth (MM/DD/YYYY)

10. Gender of primary family carepartner:

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

11. Relationship to patient:

- ◯ Spouse/Partner
- ◯ Child
- ◯ Other family member
- ◯ Friend
- ◯ Healthcare Professional
- ◯ Other

Please complete the questions below if the person completing this application is different from the primary family carepartner listed above.

12. Applicant contact information:

Name	
Company	
Country	
Email Address	
Phone Number	

13. Relationship of applicant to patient

- ◯ Spouse/Partner
- ◯ Child
- ◯ Other family member
- ◯ Friend
- ◯ Other

14. Gender of applicant

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

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Household Finances

15. Is/was the patient the primary wage earner?

- ◯ Yes
- ◯ No

16. Please indicate all that apply regarding the patient's current finances:

	Yes	No
Income from current work	☐	☐
Social Security	☐	☐
Social Security Disability	☐	☐
Pension	☐	☐
Investments	☐	☐

Other (please specify)

17. Does the patient currently have health insurance?

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

Other (please specify)

18. Does the patient have long-term care insurance?

- ◯ Yes
- ◯ No

19. If the patient does have long-term care insurance, are they currently using it?

- ◯ Yes
- ◯ No

20. Household income separate from the patient:

	Yes	No
Income from current work	☐	☐
Social Security	☐	☐
Social Security Disability	☐	☐
Pension	☐	☐
Investments	☐	☐

Other (please specify)

21. Is the primary family caregiver still currently working?

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

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Patient History and Current Care Needs

22. What is the patient's diagnosis?

- ☐ PSP (progressive supranuclear palsy)
- ☐ CBD or CBS (corticobasal degeneration or corticobasal syndrome)
- ☐ MSA (multiple system atrophy)
- ☐ Other (please specify)

23. What year did the patient begin exhibiting symptoms?

24. What year was the patient formally diagnosed with PSP/CBD/MSA?

25. If the patient has any other medical conditions, please list here:

26. What areas of daily living does the patient need assistance with? Please check all that apply:

- [ ] Showering/bathing
- [ ] Toileting
- [ ] Dressing
- [ ] Eating
- [ ] Ambulation/mobility
- [ ] Needs total assistance for all activities of daily living
- [ ] Other (please specify)

27. Which activities or tasks could the patient and/or family 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 due to mental/cognitive decline
- [ ] Carepartner respite
- [ ] Other (please specify)

28. Are you currently receiving professional care services?
Please check all that apply:

- [ ] In-home care
- [ ] Adult day care
- [ ] Skilled nursing care
- [ ] Palliative or hospice care
- [ ] Other (please specify)

  _____

- [ ] None of the above

29. If you are currently receiving professional care services, how many hours per week?

_____

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Network of Care

30. In addition to the primary family carepartner and/or professional care services named above, are there other family members or friends who help to provide care?

31. In the past, has the patient received monies from this grant program?

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

32. Has the patient ever received any other respite grants or vouchers?

- ◯ No
- ◯ Yes (please specify)

33. On a scale of 1-5, please rate the following issues as they relate to burden of caregiving on the primary family carepartner:

	Not impacted	Rarely Impacted	Neutral	Noticeably impacted	Very impacted
Stress	☐	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐	☐
Sleep Challenges	☐	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐	☐

34. Is there anything else that you would like to share about what is impacting the primary family carepartner's ability to care for the person living with PSP/CBD/MSA?

35. 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)

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Narrative

36. If you would like to share anything else about your story or how this grant would impact your family's situation, please use this space to elaborate: