CurePSP Quality of Life Respite Grant Application - April 2024

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 provide grants for 60 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.

For any inquiries about the application or the fund, please contact Joanna Teters at teters@curepsp.org.

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

CurePSP
ATTN: Joanna Teters
325 Hudson Street, Fl 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

* 1. Contact information for patient

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

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

* 3. Gender of patient

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

* 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
- ◯ 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 patient receiving direct care from their primary family care partner?

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

- ◯ 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 patient?

* 15. Relationship of applicant to patient

- ◯ 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	
ZIP	
Email Address	
Phone Number	

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Finances & Insurance

* 17. Which of these best describes the patient's combined household income from last 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 patient have?

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

Other (please specify)

* 19. Does the patient have long-term care insurance?

- ◯ Yes
- ◯ No

* 20. If the patient 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

* 21. What is the patient'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 patient begin exhibiting symptoms?

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

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

* 25. What areas of daily living does the patient 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 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/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 patient currently receiving professional care services? Please check all that apply:

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

* 28. If the patient is currently receiving professional care services, how many hours per week?

* 29. Is the patient currently receiving hospice services?

- ◯ Yes
- ◯ No

* 30. In the past, has the patient received this CurePSP respite grant?

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

* 31. Has the patient 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 how the patient/family plans to use this grant, how the wellbeing of the patient/family (e.g. emotional/physical health, stress) has been impacted by the PSP/CBD/MSA diagnosis, and how receiving this grant would positively your/their 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.

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	