PARKINSON ASSOCIATION of Northern California

BUILDING COMMUNITY FOR THE JOURNEY

PANC Respite Grant Application Date: _____

Care partner Name: _____

Address: _____

City State Zip: _____

Email address: _____

Phone number(s): Home: _____ Cell: _____

Person with Parkinson's (PwP) name: _____

Process: This application is for an annual grant of respite care services through a local Caregiver Resource Center (CRC). The grant is for $600 (minus the CRC's administration fee of $60) and must be used within 12 months. Contact with the CRC must be initiated within three months of the award date. Failure to comply with these guidelines may result in a loss of grant funding.
Applicants may apply every 12 months.

1. Please provide via email or regular mail a physician's note stating the PwP has Parkinson's Disease.
2. Please certify by initialing below that you are not receiving Medicaid funding for care.

"We (Care partner and PWP) are not receiving funding from the Federal, State or County government for in home support services" Please initial here: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to a grant, I understand that false or misleading information in my application may result in denial or loss of funding.

Care partner Signature: _____

Date: _____

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501(c)(3) Tax ID# 68-0372037