Parkinson's Network North Financial Assistance Program

The Parkinson's Network North Financial Assistance Program is designed to help with expenses associated with managing Parkinson's disease for those in need. Financial assistance can be used for in-home care, adult day centers, short-term stays at facilities when 24/7 overnight care is required, and for help to pay for medications, medical equipment, and medical procedures. Our goal is to ease the numerous stresses associated with managing Parkinson's disease for those who qualify.

How to Qualify?

To qualify for our financial assistance program, client must:

- Have a confirmed diagnosis of Parkinson's disease or related disorder.
- Reside in the five-county Grand Traverse region.
- Have a financial need to help pay for expenses associated with managing Parkinson's disease.

How to Apply for Funding?

- **Complete Financial Assistance Application by September 1, 2025:** The client or caregiver must complete the application that includes client demographics, medical, and financial information and sign an attest to the truthfulness of the information.

- **Physician Confirmed Diagnosis**: A written letter/confirmation of Parkinson's disease (or related disorder) from a physician must be provided. **This is required for review of application.**

- **Submit the Application and Diagnosis** to Parkinson's Network North, PO Box 5734, Traverse City, MI 49696. **The deadline to submit your application is September 1, 2025.**

Once you submit the application including the diagnosis, a PNN Board member will reach out to further discuss the utilization and availability of funding. Each case is reviewed on its individual merits. While we do not have specific parameters or a cut-off for income in order to qualify for the program, we ask that individuals who apply for the program have a true financial need. We appreciate your patience and understanding in this process as funding is limited and not guaranteed.

Financial Assistance Application

Primary Caregiver Information

First Name _____ Last Name_____

Mailing Address _____

City _____County_____ State _____ Zip _____

Email_____ Phone number_____

Relationship to person with Parkinson's _____

Person with Parkinson's (PwP) Information

First Name _____ Last Name_____

Mailing Address _____

City _____County_____State _____Zip _____

Email_____ Phone number_____

Birth Year _____ Year of Diagnosis _____

Neurologist's Name_____

Please circle the following demographic information related to the PD patient.

Do you have a care partner (or partners): Yes No

Type of medical insurance: Medicare Medicaid Private Carrier None

Veteran: Yes No **Currently in contact with VA:** Yes No

What products or services are you requesting on this application, and who is the provider?

☐ In-home care Provider: _____

☐ Equipment Provider: _____

☐ Medication Provider: _____

☐ Other Provider: _____

_____

_____

Please provide any additional information you feel would be helpful for us to know.

_____

_____

_____

Who referred you to apply?

_____

Physician must provide written confirmation of diagnosis of Parkinson's disease. Diagnosis can be sent directly to PNN at PO Box 5734, Traverse City, MI 49696.

**Applications submitted without a diagnosis will not be reviewed for consideration of funding.*

- I understand this request for financial aid is for temporary, short-term assistance.
- Participation in this program is based on need and the availability of funds.

I hereby release and hold Parkinson's Network North harmless from, against, and in respect of all claims, injuries, actions, demands, suits, losses, liability, or other damages that may be incurred as a result of accepting goods or services.

I attest that, to the best of my knowledge and belief, all information in the above referenced data reported is accurate and complete.

Applicant/Caregiver Signature: _____ Date: _____

Please submit completed application to:

Parkinson's Network North
PO Box 5734
Traverse City, MI 49696

For PNN use only. Do not write below this line

The amount of $_____ is approved for

_____

Provided by:

_____

Approved by: _____ Date: _____