Financial Assistance Application

Purpose

The South Dakota Parkinson Foundation provides financial assistance in support of our mission of "Empowering the Parkinson's community through education, resources, and supportive connections".

Non-Discrimination Clause

The South Dakota Parkinson Foundation provides financial assistance without regard to race, color, religion, sex, national origin, age, disability, sexual orientation, gender identity, or any other characteristic protected by law.

Confidentiality Statement

Information collected through this application will remain confidential and will be used only to evaluate eligibility for the South Dakota Parkinson Foundation financial assistance program and to facilitate payment disbursement, if approved and applicable.

Scope

Assistance is subject to meeting the eligibility criteria and the availability of budgeted funds and is not guaranteed. Applications are reviewed every Monday for consideration.

To be considered for financial assistance, all sections of this application must be completed and returned along with any required documentation to:

South Dakota Parkinson Foundation
5024 S. Bur Oak Place, Ste 217
Sioux Falls, SD 57108

For questions regarding this application, call 605-271-6113 or email info@sdparkinson.org.

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*If this form is being completed by someone other than the person for which assistance is being requested, please complete the following information (Otherwise, skip to Section 1):

Name of the Person completing the Application: _____

Relation to the Applicant: _____ **Phone Number:** _____

Email: _____

(Financial Assistance Application cont.)

SECTION 1: ELIGIBILITY CRITERIA

1. Does the applicant have a diagnosis of Parkinson's Disease, Atypical Parkinson's Disease or Parkinsonism? _____Yes _____No

   STOP: To be considered for financial assistance, you must answer "Yes" to this question. If you feel you have one of the above diagnoses, please contact your primary physician to begin the process of receiving a diagnosis. Once a diagnosis is received, you will be able to request financial assistance.

2. Does the applicant Live within the state of South Dakota or receive services in South Dakota for which your request for financial assistance is made.

   _____Yes _____No

   STOP: To be considered for financial assistance, you must answer "Yes" to this question. If you answered "No" you do not qualify at this time.

3. Has the applicant verified that all insurance policies to which they are covered under do not cover their request under the insurance policy?

   _____Yes _____No

   STOP: To be good stewards of our money and ensure you get the benefits for which you pay, this step must be completed prior to submitting an application.

SECTION 2: APPLICANT INFORMATION

(This is the person who needs the requested funds)

Full Name: _____ Phone Number: _____

Street Address: _____ City, State, Zip: _____

Email Address: _____

(Financial Assistance Application cont.)

SECTION 3: ASSISTANCE REQUESTED

Type of Assistance Needed (Check all that apply):

[ ] Exercise Programming **[ ] Home Modifications** **[ ] In-Home Care**

[ ] Medical Equipment/Adaptive Devices **[ ] Therapies** **[ ] Other**

Please further describe assistance needed *(i.e. "I attend Rock Steady Boxing in Sioux Falls)*

_____

_____

Total Amount Requested: $_____

Have you applied for assistance for the requested item or service from another source?

_____Yes _____No

If Yes, please explain:_____

SECTION 4: REQUIRED DOCUMENTATION

Please submit this application along with the requested documentation (if applicable):

- ✓ **RECEIPTS OR PROOF OF ESTIMATED COST: Provide a receipt or cost estimate for the item or service you are requesting reimbursement or coverage for.** If already purchased, the item or service must have been purchased within 90 days of the application date.
- ✓ **INSURANCE COVERAGE: Proof that insurance coverage was reviewed and does not cover the requested service or item for which this request is being made.** *This could be notes from calls you made with date/time and who you talked with. It does not mean you have to submit to insurance and get a denial if you know they do not cover it. Proof could also be a statement from you, if you know without a doubt based on previous conversations or experience that your insurance(s) does not cover the item or service (i.e. not a covered item or your benefit has already been used for the benefit period).*

Notes:_____

_____

(Financial Assistance Application cont.)

- ✓ **DIAGNOSIS VERIFICATION: A letter or documentation from your healthcare professional certifying your diagnosis of Parkinson's disease, Atypical Parkinson's Disease, or Parkinsonism. You can use the section below to serve as the needed verification or attach a separate letter or documentation to this application.** *(i.e. doctor, therapist, or copy of diagnosis from your healthcare chart)* *This would only need to be provided when applying for the first time with this application.*

☐ Check here if you have already provided proof of diagnosis.

To the best of my knowledge and/or based on available records, I verify that the applicant has been diagnosed with Parkinson's disease, Atypical Parkinson's Disease, or Parkinsonism.

Signature: _____ **Date:** _____

Printed Name: _____

Title/Credentials:_____**Organization/Phone:**_____

Upon approval of application, who should payment be made to? *(i.e. Vendor/Exercise Program. If you are requesting that the funds be sent directly to you, please put "N/A"):*

Business Name: _____

Business Address (if known): _____

Contact Person *(if known)*: _____ **Phone:** _____

SECTION 5 ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I certify that all information provided in this application is true and accurate to the best of my knowledge. I understand that providing false information will result in immediate denial. I authorize the South Dakota Parkinson Foundation to verify any information provided herein relative to this request.

Applicant Signature: _____ **Date:** _____