

May, June, July 2013

# INDY PD UPDATE

PRODUCED AND DISTRIBUTED BY: PAACI  
PARKINSON'S AWARENESS ASSOCIATION OF CENTRAL INDIANA, INC.

## September 21, 2013 Symposium... Cognition & Nutrition in Parkinson's

Indy West Conference Center  
400 N. High School Rd., Indpls., IN  
Doors open at noon, program 1-4pm  
(Watch for more details)

### Dues Reminder

If you haven't paid your dues for 2013, please pay them now. It's \$25/year for a family of up to 4 people. Paying your dues gives you a discount on your Symposium tickets, a tax deductible donation, and helps keep PAACI up and running.

Contact us at:  
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**\$20 per non-dues paying single  
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four people**

### Breaking News!!!

PAACI has launched a new respite care subsidy program called PAACI Cares!. See the back cover for more details.

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## Helpful Phone Numbers

American Parkinson's Disease Assoc.-800-223-2732  
 Aqua classes—317-547-8349  
 Caregivers Spt Grp w/Catholic Charities—317-261-3378  
 CICOA—317-254-5465  
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 Chair exercise classes—317-872-4567  
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 Indiana Parkinson's Foundation—317-630-0315  
 Indiana Reading & Information Services—317-715-2004  
 National Parkinson's Foundation-1-800-473-4636  
 Parkinson's Action Network- 800-850-4726  
 Parkinson's Disease Foundation-(212) 923-4700  
 Physical therapy—317-823-6841  
 Rock Steady Boxing—317-205-9198  
 Rx for Indiana—1-877-793-0765  
 Shelby Cty PD Exercise & Support—317-398-7614  
 (Currently limited to Shelby County residents and Major Health Partners patients)  
 Southside Support Group—Contact Judy Clodfelter at clodfeltj@msdmail.net  
 The Climb North—317-774-7252  
 The Climb South—317-946-5340  
 Westside Support Group—317-244-4463  
 Young Parkinsons of Indiana—317-203-3049

## PAACI Numbers:

**PAACI Office**—317-255-1993

**Parkinson's Care Partner Support Group (For Caregivers)**  
 (317) 902-7373

## Newsletter

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**Arranged & Edited by** Sheri Kauffman

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## Reaching for Respite

by Nancy Pressner, R.N. B.S.N.

Respite: a short interval of rest or relief. The definition of the word itself is brief and simple. What is not so simple is recognizing, as a caregiver, that it's time to seek respite. It is often also not easy to determine how to pay for it.

At first, when beginning to take care of a spouse, parent, or other loved one with Parkinson's, things move slowly. Symptoms are present as are changes that make it a little more difficult for the patient to do small things in everyday life. Some assistance is needed by the caregiver for fine motor skills, getting out of a chair or watching for potential fall risks due to balance and gait issues. Adjustments are made in the daily routine and environment but the patient and caregiver can still keep things mostly normal and do their own thing.

Then the plateau and decline waves begin. Things get a little worse as more symptoms appear and more help is needed from the caregiver to accomplish daily tasks such as grooming, dressing and eating. This becomes the new norm until the next period of decline sets in. Each phase requires more time and responsibility on the part of the primary caregiver. I know from personal experience after caring 24/7 for my husband the past seven years, we like to think we can do it all and that extra help from the outside isn't needed. Sometimes it is the person with Parkinson's who refuses to get the extra help due to cost, unfamiliarity or discomfort with strangers, or the plain fact that they often can't see how difficult things are getting for them and for us.

The important fact in all of this is to remember that this is not a short term disease in most cases. Whether your loved one remains at home or needs long term care in a facility, you will be needed as a caregiver for hands on care or the constant overseeing of hands on care provided by someone else. Depending on your age and health status you may run into unforeseen problems of your own along the way and we all know stress of this magnitude is not kind to us physically or mentally. This is why respite care is so important.

Respite care can be provided in the home, in a long term care facility, or in an adult day care setting. It gives the caregiver a much needed break. Time can be used to run errands, sleep, get those undone projects done, or sit and just think about your needs for a few minutes or hours. There is something very freeing in having just a short period of time during which your loved one is in capable hands other than your own. We love them and give them all the best we have in attention, compassion, and act as their anchor through this long and challenging journey. We deserve the respite and they want what is best for us. Recharging our batteries makes us more patient and at times enables us to see things with a fresh perspective when we return home. It gives us back just a little piece of normalcy for a brief period of time. We can do the things that make us feel like us again like going shopping, going to lunch with a friend, or taking a walk. It doesn't make Parkinson's or the responsibilities of caregiving go away, but it does make us think about other things that are still out there in life.

The means by which to pay for respite care varies. Your physician's office, hospital social worker or local Council on Aging are a few of the resources available to answer your questions on what insurances, veterans programs, or Medicaid /Medicare benefits are available for this type of care, and how you become eligible. Some care must be paid for out-of-pocket. This is where PAACI has attempted to be of assistance with the new program, PAACI Cares, which will help subsidize the cost of care to qualifying families. See the article on the back cover of this newsletter for more information on the new program. Consider respite and actively seek it for the sake of your well being and the one you love and care for. It is a welcome and refreshing oasis in this difficult journey.

# Filing for Social Security Disability

By Joseph Pressner, Ph.D.

The first article in this series described in some detail the process for filing for Social Security Disability. This article focuses particularly on the ins and outs of filing for disability due to Parkinson's Disease and related conditions.

Parkinson's Disease is included in the Social Security listings of neurological impairments. (the 11.00 section) This is the same section that applies to diseases such as epilepsy, cerebral palsy, muscular dystrophy, multiple sclerosis, etc.

The specific listing for Parkinson's Disease is number 11.06. This section indicates that Parkinson's Disease is considered disabling for purposes of Social Security when there is "Significant rigidity, bradykinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station."

This listing sounds pretty straightforward. Where the murkiness begins is in that word "Significant." For example, a tremor might be seen as "significant" by some and not so "significant" by others. Similarly there may be disagreements in terms of how one identifies "sustained disturbance of gross and dexterous movements" or "gait and station."

This, in fact, is one of the reasons for the appeals process described in the previous article, and why it is important to pursue a claim even if denied at the initial level. Even if the initial adjudicator and physician believe that some part of the definition is lacking, subsequent reviewers or an administrative law judge may find that the listing has been met.

The important thing is that you and your doctor need to know how disability is described by the regulations in regard to Parkinson's Disease so that you and your doctor can supply the strongest evidence indicating that the quoted section of the regulations have been met.

There are several other things to also remember.

The first of these is that as a person approaches retirement age it becomes more probable that an individual's claim may be allowed. The regulations take age, education, and work history into account as one begins to age.

Maybe an over-simplified example would help. Suppose that a 30-years-old loses an arm in an accident. If this individual applied for disability, the claim would probably be denied since there are jobs that such an individual could do that do not require the use of both limbs.

Suppose, however, that a 64-years-old who has worked all of his life as a machinist has a similar accident. That person's claim might be allowed since it is probable that the claimant cannot perform his old job, and will be unable to train for a new type of occupation before reaching retirement age.

Let's change the example another time. Suppose that this 64-year-old man who lost his arm is not a machinist, but a psychologist. That psychologist's claim would probably be denied, since he would not need the arm to be able to provide psychotherapy to his patients.

The second thing to remember is that even if the primary condition is Parkinson's Disease, it is very possible that an individual who may not meet the disability criteria for Parkinson's Disease described in the third paragraph of this article might qualify for benefits under another disability listing.

Parkinson's Disease can affect a person in so many other ways besides neurologic problems. For example depression is very common in individuals with Parkinson's Disease. This may in some cases be due to the disease itself. In other cases it may be due to the person's emotional response to the disease. For purposes of a disability claim it really doesn't matter which it is: depression is depression. In fact, the depression may become so severe that it is even more disabling than the neurologic problems. Depression is evaluated by Social Security under listing 12.04.

Another unfortunate result of Parkinson's Disease may be dementia. This would be evaluated under listing 12.02.

Thus if you or your loved one is suffering from one of these conditions it is important to file for disability benefits not only under the Parkinson's listing (11.06) but also under additional listings such as depression (12.04) and dementia (12.02).

In order to be found disabled due to depression or dementia, the individual must be “markedly” limited in two of three areas (there is a fourth, but it probably would not be applicable in these cases). The three factors are activities of daily living, social functioning, and concentration/pace/persistence.

Again, this may seem fairly straightforward, but the murkiness comes into play with the understanding of “markedly limited.” What one reviewer sees as a “moderate” limitations, might well be seen by another as a “marked limitation.”

So what are reviewers actually looking for with these three factors? Activities of daily living are the basic activities of self-care, chores, recreational pursuits, etc. Social functioning involves how people relate to other people – especially people outside of the immediate family. People can have terrible family relationships, and yet have no problems relating to people on the job. That’s why relationships outside of the family are so important to evaluate. Concentration, pace and persistence are inter-related and involve how well the person keeps his mind on what he is doing, and whether the person can sustain an activity for an extended period of time.

There is one absolutely critical thing to keep in mind if one is applying for disability benefits because of something like depression or dementia. The limitations in activities of daily living, social functioning and concentration/pace/persistence MUST be due to the depression or dementia – NOT the Parkinson’s Disease.

That may seem a bit confusing. An example may help. A person might, for example, be very limited in his ability to wash dishes because of severe tremors. That would be a severe limitation in activities of daily living. However, that would NOT be due to depression or to dementia. If, in fact, one is claiming disability due to depression, then the important thing would be whether or not the person is so depressed that the person simply cannot attempt to wash the dishes. Or if someone is claiming disability due to dementia, perhaps the limitation would be that the person forgets to do the dishes, or maybe can’t remember exactly how to operate the dishwasher.

I do not want to give the impression that an individual should apply for only one condition. In fact, it is imperative that ALL limiting conditions should be reported. At times an individual may be found disabled on the basis of a combination of impairments rather than one specific condition. If a person is suffering from Parkinson’s Disease, and dementia, and depression then all three conditions should be alleged to be disabling.

However in such a case it is important to,

- 1) describe in detail how the Parkinson’s Disease is limiting in a neurological sense;
- 2) describe in detail how the depression is limiting all by itself;
- 3) describe in detail how the dementia is limiting all by itself.

In my opinion the most maddening thing about the social security disability program is that at times when these distinctions are not clearly made, it does not get all sorted out until the case reaches the administrative law judge level. In the end the correct decision might be made, but this may take many months.

Finally, it may be helpful to also keep in mind that several Parkinson related conditions are eligible for ‘fast tracking’ (called “compassionate allowances” in Social Security lingo) because they are so severe that they often lead to allowances. These include Corticobasal Degeneration, Lewy Body Dementia, Multiple System Atrophy, Parkinson’s Dementia, Progressive Supranuclear Palsy, and The ALS/Parkinsonism Dementia Complex. Certainly anyone who has been diagnosed with one of these conditions should not wait to apply.

Hopefully this article provides some additional insight into the disability process so that individuals suffering from Parkinson’s Disease and their family members can effectively structure their claims.

I think, however, in closing that I clearly state that this article represents my personal understanding of the disability process and should not be considered as any representation of the Social Security administration nor the state disability determination bureau.

## Parkinson's Awareness Celebration

On April 15th all of the local Parkinson's groups came together with Dr. Mohamed Hassan and Teva Pharmaceuticals to celebrate Parkinson's Awareness Month. Almost 200 people with Parkinson's, their families, friends and caregivers came to enjoy a good meal and listen to Dr. Hassan's presentation. Then we had



the opportunity to hear a little about each of the groups that were represented at this very successful event including the Parkinson's Awareness Association of Central Indiana, Inc., the Indiana Parkinson's Foundation, Rock Steady Boxing, the Parkinson's Disease Foundation, the Worlds Parkinson's Congress, Young Parkinsons of Indiana, and Positive Directions. Afterwards, Dr. Hassan took questions from the audience, staying until everyone's questions were answered. Below is an article discussed by Dr. Hassan from the Teva newsletter, Life in Balance which can be found at [www.parkinsonshealth.com](http://www.parkinsonshealth.com).

Once you've been diagnosed with Parkinson's disease (PD), your treatment plan may start with just one drug and continue for sometime— maybe even sev-

eral years. However, as your condition evolves, your doctor may recommend changing that plan by adding other drugs to your treatment regimen.

Some patients may question why one or more drugs might be "layered" on top of the drug that has been part of their long-term treatment.

Why not just replace the old drug with another? Why use multiple drugs when just one has been used for so long? The answer lies in understanding how PD affects the body and how different PD drugs work in different ways in the brain.

The roles of neurons and synapses in brain function—The brain contains many neurons, or nerve cells. These cells send electrical impulses to each other by passing through an area between the cells called a synapse. The parts of a synapse include the presynaptic neuron - the place where the impulse starts in one neuron—and the postsynaptic neuron, the area where the moving impulse is received by another neuron. Normally, neurons located in a specific area of the brain called the substantia nigra produce dopamine. Dopamine is a chemical produced by a neuron and then picked up by dopamine receptors on another neuron. Dopamine transmits

## Treatment with Multiple PD Medications

messages between different neurons in the brain which control movement. In PD, these particular neurons become damaged or begin to die, which affects the production of dopamine. As a result, the brain becomes unable to properly control movement. Mohamed N. Hassan, MD, PhD, neurology and pharmacologist at Hartford Hospital, in Hartford Connecticut, notes that in PD patients, these neurons still produce dopamine, but not in sufficient amounts. "And that's not the only problem," he adds. "The problem is that dopamine, once it acts, is removed from the synapse. Some of it is taken back up into the presynaptic neuron, but the rest of it is transported out of the synapse and degraded ...And so, you're losing dopamine."

Dr. Hassan uses the analogy of a leaky bucket to explain what's happening. In PD, the loss of dopamine from the synapse is like a hole in a bucket that allows dopamine to leak out. Since patients with Parkinson's aren't making enough dopamine, it's important to both keep the bucket as full as possible as well as to prevent the dopamine from leaking out.

## Multiple Medications Continued...

The role of multiple medications—Dr. Hassan continues the bucket analogy to explain why a number of medications are used in PD. Patients continue to make their own dopamine and may even take levodopa, which becomes dopamine in the brain. This is helping to fill the bucket. At the same time, it's important to block the breakdown of dopamine—or help plug the hole in the bucket—with a medication such as an MAO-B inhibitor.

Both of these actions help enhance dopamine levels in the brain and work along with dopamine agonists to increase dopamine activity. “And that will give a better stimulation of the receptors and the improvement of Parkinson’s symptoms,” Dr. Hassan says. Medication options include several different types of classes, of drugs. These medications either enhance or mimic dopamine in different ways to help control motor symptoms. These drugs can be used individually or together because they have different mechanisms of action and can therefore provide different benefits in managing PD. In addition, Dr. Hassan notes, using different drugs at the same time to treat PD may help with other issues. “By using 2 or 3 classes of drugs, you can keep the doses low to prevent side effects that may occur at high doses,” he explains. He adds that by supplementing levodopa with other drugs at low dosages, you have fewer changes of inducing side effects. Dr. Hassan uses another analogy to explain why multiple medication might be prescribed in PD treatment: “For example, you have a car that gives you 30 miles per gallon, and you put an additive in the tank. And now, you get 35 miles per gallon. You’re using an additive that helps to increase the duration of action of levodopa.



MAO-B inhibitors, COMT inhibitors, dopamine agonists, and levodopa all work differently in the brain. Here is more information on how these treatment options work.

**Levodopa:** Levodopa converts to dopamine in the brain, helping to replace the brain’s diminished supply of dopamine. Levodopa is a cornerstone PD therapy that many patients will eventually be prescribed.

**MAO-B inhibitors:** MAO-B is an enzyme that breaks down the dopamine in the brain. MAO-B inhibitors help prevent dopamine from being broken down, so more of your brain’s dopamine is preserved.

**Dopamine agonists:** Dopamine agonists act like dopamine in the brain, mimicking the effects of dopamine.

Dr. Hassan also discussed and outlined the important members that should be included in your healthcare team including:

- ◆ Family & Caregivers
- ◆ Neurologist
- ◆ Nurse, Nurse Practitioners & Physician’s Assistant
- ◆ Speech Therapist
- ◆ Occupational & Physical Therapist
- ◆ Social Worker
- ◆ Primary Care Practitioner
- ◆ Support Groups

## **Five Reasons Why Your Body and Mind Will Love Tai-Chi**

Characterized by fluid, slow continuous, and mindful movements that are coordinated with relaxed breathing, Tai Chi is gaining in popularity in the United States as an exercise which heals both the body and the mind. Is this gentle form of exercise right for you? Here are 5 reasons why you might want to take a class or two and find out.

***Tai Chi alleviates and mitigates the symptoms of many age-related chronic conditions.*** Referred to by the Harvard Medical School as “medication in motion”. Tai Chi provides research-supported healing and support for those with memory loss, dementia, arthritis, heart disease, high blood pressure, sleeplessness, fibromyalgia, diabetes, Parkinson’s disease and back and spinal problems, as well as reducing stress and increasing physical strength, mobility, balance, and endurance.

Well-respected medical groups now view Tai Chi as a viable complementary medical therapy. Peter M. Wayne, assistant professor of medicine at Harvard Medical School and director of the Tai Chi and Mind-Body Research Program at the School’s Osher Research Center agrees and notes, “A growing body of carefully conducted research is building a compelling case for Tai Chi as an adjunct to standard medical treatment for the prevention and rehabilitation of many conditions commonly associated with age.”

***Tai Chi helps you lose weight.*** Don’t let the gentle moves fool you—30 minutes of Tai Chi burns the same amount of calories as thirty minutes of brisk walking.

***Tai Chi helps you keep your balance and prevents falls.*** According to the CDC, falls are the number one reason that individuals age 45 and older visit the emergency room. Out of those who do fall, 45% will die within the first year from complications due to that incident. Of the ones that survive, 50% of them will never regain total mobility. The movements performed in Tai Chi build strength and vastly improve one’s balance over time. In a study conducted by Steven L. Wolf, PhD, a rehabilitation medicine spe-

cialist at Emory University School of Medicine in Atlanta, 215 people aged 70 and older were assigned to three groups. One group practiced Tai Chi three times weekly. Another got computerized balance training using machines that help people relearn balance after a fall. A third group did no exercise, but met to discuss issues relating to the elderly. Seventeen months after the training stopped, **the Tai Chi practitioners had reduced their risk of falls by nearly half.** To further emphasize how effective Tai Chi is in helping with fall prevention, in early 2011, the American Geriatrics Society and the British Geriatric Society updated their guidelines on fall prevention strategies to include “cutting back on the medication and doing more Tai Chi.

***Tai Chi improves your memory and it may even make your brain grow.*** Tai Chi also has benefit for the brain’s hippocampus, where memories are processed. One international study conducted by a team of neurologists from Florida and Shanghai found that individuals who practiced Tai Chi three times a week actually developed an increase in brain size and improved their scores on psychological tests for cognition and memory. No such results were seen in the control group that had no intervention. They noted that their findings suggested Tai Chi improves memory and may help delay the onset of dementia.

***Tai Chi is fun to do and has no barriers!*** Tai Chi can be practiced regardless of age, weight, or physical ability although some forms are more suitable for certain individuals than others. It requires no special equipment or special clothing and can be done from standing and seated position. These are exercises that can be practiced for a lifetime.

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## Telemedicine Can Increase Quality of Care for People with Parkinson's, Reduce Costs

Did you know 42% of people with Parkinson's don't get the specialized care of a neurologist or movement disorder specialist and see only a general practitioner for their Parkinson's-related healthcare needs? Did you know that people in 20 of 23 counties in Maryland do not have access to a Parkinson's disease specialist? Research has shown that people with Parkinson's who receive specialized care are better able to manage their symptoms and the disease. Because specialized care isn't something found in every city and town across America, being able to see a neurologist using already-available everyday technology is an attractive and reasonable option.

Telemedicine is the remote delivery of healthcare services and clinical information using telecommunications technology including internet, cellular, wireless, satellite, and telephone. According to the American Telemedicine Association (ATA), more than half of U.S. hospitals now use some form of telemedicine, and in 2011 the Veterans Administration conducted more than 300,000 consultations via telemedicine.

The ATA reports that telemedicine provides a number of benefits: Lowered healthcare costs, improved quality of care and outcomes, expanded reach of doctors and specialists to remote areas, and fewer and shorter hospital stays, to name a few.

For the Parkinson's community, telemedicine has the potential to be a powerfully valuable service in terms of quality of life, better management of symptoms, and greater patient well-being. But, because of current laws, telemedicine is currently limited in scope and availability so those who need it most can't access it or benefit from it. How can we change that?

The Parkinson's Action Network (PAN) is focusing on telemedicine from a policy perspective in two specific areas where we believe we can have an impact: state licensure issues and Medicare reimbursement.

State-based medical licensing presents a barrier to doctors using telemedicine to see patients across state lines if the doctor is not licensed in the same state as the patient. Because there are a limited number of neurologist in certain states, people with Parkinson's may need or want to see a doctor in another state. PAN is working with colleagues on Capitol Hill to explore possible federal legislative solutions to this issue.

When it comes to Medicare reimbursement, Medicare beneficiaries are eligible for telemedicine services only if they are presented from an originating site located in a rural Health Professional Shortage Area (HPSA) or in a county outside a Metropolitan Statistical Area (MSA). This is frustrating because nearly 80% of Medicare beneficiaries do not live in an HPSA or counties not in an MSA, so they don't qualify for telemedicine. This is another issue PAN is working on in partnership with other patient advocacy organizations whose constituents also need greater Medicare coverage options.

Amy Comstock Rick, PAN CEO, believes telemedicine could make a tremendous difference in the lives of people with Parkinson's. "Seeing a neurologist or movement disorder specialist makes a world of difference for someone living with Parkinson's," she said. "Unfortunately, this may mean driving for hours and hours to see one, if there even is a specialist in their state. We're exploring issues around telemedicine policy to determine where we can have a real impact on behalf of the Parkinson's community," she said.

The Parkinson's Action Network hosted a panel discussion on the issue of telemedicine at its 2013 PAN Forum in February. Dr. Ray Dorsey (John Hopkins University), Dr. Peter Schmidt (National Parkinson Foundation), and Dr. Guy Wilcox (Utica, NY) presented their thoughts, data, and ideas on where telemedicine is headed and how the removal of licensure and Medicare barriers could make a positive impact. The panelists also discussed the fact that neurologist can provide the same high-quality care via telemedicine that they do in-person in their offices.

The conversation will continue next month when PAN, along with other national Parkinson's organizations, co-hosts of the 2013 Merinoff Symposia, which is entirely focused on Parkinson's disease and telemedicine (held April 9-11).

Telemedicine is important to not just the Parkinson's community. PAN is working with other patient advocacy organizations—including the American Heart Association and the National Multiple Sclerosis Society—to identify, from a broad patient advocacy perspective, how federal policy can support telemedicine as an option for those who need specialized care. "If we can remove barriers to the kind of care people with Parkinson's deserve, it will have ripple effects across the spectrum of disease care we can't even begin to calculate," added Rick. "We are excited to be working with other patient advocacy groups on this, and want to make a real difference."

\*\*Reprinted with permission from the Parkinson's Action Network.

## Rest in Peace Dear Friends...

Kerry Lee Ackley	Duane Hill
Dale Auerbach	Bill Israel
Gene Bauer	Don Leffel
Wilbur Bauer	Gerald Jerry Lindsey
Theodore Blackford	Bill Marrow
R. Robert Blessman	Carolyn McClure
Dr. Robert Brightwell	Anita Michael
Mary Comstock	Bill Gene Morrow
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Jay Cottman	Gerald Scofield
Helen Davis	Gene Smith
Dale Deckard	Norman Eugene Smith
Bob Deckard	Donald J. Thompson
Ralph Vernon Earle Jr.	August "Augie" Tindell
Richard "Dick" Fields	Dr. Moo Nahm Yum
Garland L. Fredrick	
Larry Hammond	
Gaynard Hardebeck	
Donald Haynam	
Minnie Herrell	

*Happy 25th  
Anniversary to John &  
Kathy Winay*

### Happy Birthday!

Elaine Atlas & Art Atlas  
Bev Bercovitz  
R.E. Burkhardt  
Norman Shupe



**Honorariums...** Some of our PD friends like to honor their friends and/or loved ones with a donations. Our honorees in this Newsletter are Gail Morrison & Fred Schmidt.

**Multiple Donations ...Special thoughts and thanks to our friends who have made several donations to PAACI over the last few months including...** Martin & Carol Zagarinsky, Emmy Bachmann, Mary Skinner and Charles & Mary Matsumoto



**Donations made in loving remembrance of...**  
Floyd Chandler  
James Skinner &  
Fred Bachmann.

**Dues Paid**  
Thank you to all our dues paying members. We appreciate your support.

Kaye Auerbach, Emmy Bachmann, Kathy Banta, Lanie Bertram, Jim Carlson, Joe Carney, James & Vera Casper, Dick & Dorothy Crane, Robert & Eleanor Darby, Cheryl Dilk, Richard & Judith Doran, Judith East & Michael Jeffries, David & Deloris Garrett, Donald & Suzanne Huizinga, Tom Irwin, Sarah Kempfer, Charles & Mary Matsumoto, Margie & Debra Nackenhorst, Rebecca Parks, Roleen Pickard, Julia Pratt, Randy & Jayne Rains, Tom & Marilyn Ransom, Jimmy & Lucy Reed, Alexander & Cece Rodger, Fredrik Spier, George & Helen Spradling, Carl & Linda Stafford, William & Judith Summitt, Richard and Carol Thorne, Rosemary Ward, Martin & Carol Zagarinsky

*PAACI is so grateful for your donations. Thank you for thinking of us in all you do.*

**Bequests are** donations planned lovingly long in advance, placed in your will, to be given upon your passing. As much as we all know how difficult this kind of planning is, your thoughtfulness really matters to us. **Thanks you so much!**

## Multiple Memorial Donations

Special thanks to our members' families who thought of PAACI at a very difficult time in their lives. These are our members whose families remembered us in their loved ones obituaries or at their memorial services. **Thanks to the families of Helen Davis, Richard Fields, Gaynard Hardebeck, Don Haynam, Minnie Herrell, Anita Michael, William H. Palmby, Donald Thompson and Dr. Moo Nahm Yum.**

**Donations of \$100 & over**

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## **Stay up to date...get the breaking news on PD with email blasts**

In an effort to keep the Parkinson's community more up to date and current, we are sending out more email blasts. If you would like to receive the most up-to-date information regarding local PD events, webinars, or any new information available please send your email address to:  
[sheripaaci@sbcglobal.net](mailto:sheripaaci@sbcglobal.net) or  
text PARKINSONS to 22828.

## **PAACI Cares!**

The first initiative of PAACI Cares! is to help off-set the cost of respite care. Respite care refers to the opportunity for the care provider and the person affected by Parkinson disease to get a break. The kick-off to the PAACI Cares! Respite program allows caregivers up to \$500.00 per year in assistance to subsidize the cost of respite care for in-home care.

If approved, the subsidy is paid directly to the agency after the respite care has been provided and appropriate documentation has been submitted. There will be a list of respite care providers from which you can choose one that would work for your situation. There is an application process which explains the qualification process. These forms are available by calling the PAACI office at (317)255-1993 or by emailing [sheripaaci@sbcglobal.net](mailto:sheripaaci@sbcglobal.net). For 2013, funds will be limited to those residing in Marion County and a PAACI member in good standing (dues current). Review of applications will begin April 30, 2013.

## **Want to help?**

PAACI would like to help as many people as possible through the PAACI Cares! Program. If you would like to help, please consider making a tax-deductible donation designated for "PAACI Cares!".

- Every \$25 tax-deductible donation pays for two hours of respite care for someone in need and a \$500 donation pays for one more PAACI Cares! Grant, which means one more person we can help. Please use the enclosed envelope and just mark it "PAACI Cares!"