

**MEDICAL NEED VERIFICATION**

Dear Healthcare or Social Work Professional,

Your patient's family caregiver is applying for the Arizona Family Caregiver Reimbursement Program (FCRP) through the Arizona Department of Economic Security, Division of Aging and Adult Services (DAAS). The FCRP is designed to reimburse family caregivers 50% of purchases up to \$1,000 (per qualified family member). Qualified expenses include costs for home modifications or assistive care technology to keep the patient mobile, safe or independent.

DAAS requires a Medical Need Verification Form to be completed and signed by the Primary Care Provider (PCP), Nurse Practitioner (NP), Physician's Assistant (PA), a case manager, or care coordinator to verify the patient requires assistance with one or more activities of daily living (ADLs).

For questions, contact the Arizona Caregiver Coalition at (888) 737-7494.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Caregiver Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**Mark all assistance with ADL's that apply:**

Toileting  Bathing  Dressing  Walking  Eating  Transferring

**TO BE COMPLETED BY HEALTHCARE OR SOCIAL WORK PROFESSIONAL**

Your timely response is requested, the patient will be denied approval per the requirements for the Arizona Family Caregiver Reimbursement Program. Your signature certifies that your patient requires assistance with the selected ADLs.

Physician: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Practitioner (NP) or Physician's Assistant (PA): \_\_\_\_\_

Provider Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Case Manager or Care Coordinator: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign and return this document to the family caregiver contact noted below OR fax directly to the Arizona Caregiver Coalition at 888-288-6293.

Patient Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**RETURN COMPLETED FORM TO**

Family caregivers may return the form with the application packet via email to [CRL@AZcaregiver.org](mailto:CRL@AZcaregiver.org), fax 888-288-6293, or mail to Arizona Caregiver Coalition P.O. Box 21623 Phoenix, AZ 85036.

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Aging and Adult Services at 602-542-4446; TTY/TDD Services 7-1-1 • Disponible en español en línea o en la oficina local