Arizona Caregiver Coalition
Serving the Needs of Arizona Caregivers

Arizona Caregiver Coalition Respite Programs Medical Needs Form

Dear Healthcare, Social Work, or DDD Professional:

Your patient/client's family caregiver is applying for the Respite Voucher Program through the Arizona Caregiver Coalition. This program helps reimburse family caregivers up to $1,200 to hire a provider to care for the patient to allow the caregiver to receive respite.

We require a Medical Needs Verification form to be completed by the indicated professionals to verify that the patient requires assistance with one or more activities of daily living (ADL's) that would justify the patient's need for caregiving.

Patient Name: _____

Caregiver Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Please mark all assistance with ADL's that apply:

☐ Toileting ☐ Bathing ☐ Dressing ☐ Walking ☐ Eating

☐ Transferring/Mobility ☐ Other (please specify): _____

*You may use the back of this form to provide further information if needed.

TO BE COMPLETED BY HEALTHCARE, SOCIAL WORK, OR DDD PROFESSIONAL ONLY:

☐ Physician ☐ Nurse Practitioner ☐ Case Manager ☐ DDD Support Coordinator

☐ Social Worker ☐ Other (please specify): _____

Provider Name: _____

Provider Address: _____

Signature: _____

Date: _____

Please sign and return this document to the family caregiver. You or the family caregiver may return the form by email to info@azcaregiver.org, fax to 888-288-6293, or mail to Arizona Caregiver Coalition P.O Box 21623 Phoenix, AZ 85036.