Arizona Department of Economic Security
Child and Community Services Division

Verification of Unable/Unavailable Status

Client's Name *(Last, First, M.I.)*: _____

Client ID No.: _____ Phone No.: _____

Client's Address *(No., Street, City, State, ZIP)*: _____ Apt #: _____

Child Care Specialist's Name: _____

FAX No.: _____ Phone No.: _____

By signing this form, I authorize the below-named organization or person to release the information requested.

Client's *(or Authorized Representative's)* Signature: _____ Date: _____

The client listed above has authorized the release of information requested below and requests child care based on their inability or unavailability to provide adequate child care to their child(ren) for any portion of a 24-hour day. The information provided will become part of a permanent file with access limited to representatives of DES and the client or the client's authorized representative.

Reason for Child Care Services: Completed By Organization or Person

☐ **Medical Reasons:** Child Care is requested due to a mental, physical, or emotional condition. *(Must be verified by a licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist, or behavioral health specialist.)*

1. Patient's Name *(First, M.I., Last)*: _____
2. Diagnosis: _____
3. Describe how the medical condition prohibits the patient from caring for their child(ren):

_____

4. Enter the Patient's Anticipated Date of Recovery or Next Medical Evaluation Date: _____

☐ Check to indicate the medical condition is indefinite or lifelong *(Check requires the signature of one of the specialists listed above)*.

Signature: _____ Title: _____

☐ **Drug/Alcohol Rehabilitation Participant:** Child Care is requested due to participation in an outpatient drug/alcohol treatment/ rehabilitation program. *(Must be verified by a program counselor or administrator.)*

1. Participant's Name *(First, M.I., Last)*: _____
2. Drug/Alcohol Rehabilitation Program Participation Schedule: _____
3. Participation Start Date: _____ and Participation End Date: _____

☐ **Court-Ordered Community Service Participant:** Child Care is requested due to participation in a court-mandated activity. *(Must be verified by a probation officer or court official.)*

1. Participant's Name *(First, M.I., Last)*: _____
2. Participation Start Date: _____ and Participation End Date: _____

See reverse for EOE/ADA disclosures

Person Providing Information: ***(Must be a licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist, behavioral health specialist, program counselor, program administrator, probation officer or court official.)***

Name *(Print or Type)*: _____

Title: _____ Phone No: _____

Signature: _____ Date: _____