ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

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 Code: ______

Child Care Specialist's Name: ______

FAX No.: ______ Phone No: ______

I authorize the below named organization or person to release the information requested.

Patient/Participant's Name *(Last, First, M.I.) – (Print or Type)*: ______

Patient/Participant's Signature: ______ Date: ______

The patient or program participant listed above has authorized the release of information requested below, and is requesting child care based on their inability or unavailability to provide adequate child care to their child(ren). 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 PROVIDING INFORMATION

MEDICAL REASONS: Child Care is requested due to a mental, physical, or emotional disability. (Must be verified by a licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist or behavioral health specialist.)

1. Diagnosis: ______
2. Prognosis: ______
3. Description of Treatment Plan Needed for Specified Illness:
   ______
4. Description of How the Nature of Client's Impairment Precludes Provision of Child Care:
   ______
5. Length of Time Child Care Required: No. hours per day: ______ No. days per week: ______
   Duration *(MM/DD/YYYY)* From: ______ To: ______
   Anticipated Date of Recovery: ______

DRUG REHABILITATION PARTICIPANT: Child Care is requested due to participation in a drug treatment/ rehabilitation program. (Must be verified by a treatment program counselor or administrator.)

1. Description of Treatment Plan:
   ______
2. Drug Rehabilitation Participation Schedule: ______
3. Length of Time Child Care Required: No. hours per day: ______ No. days per week: ______
   Duration *(MM/DD/YYYY)* From: ______ To: ______
   Anticipated Date of Recovery: ______

See page 2 for EOE/ADA disclosures

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. Length of Time Child Care Required: No. hours per day: ________ No. days per week: ________

   Duration *(MM/DD/YYYY)* From: ____________ To: ____________

PERSON PROVIDING INFORMATION: ***(Must be a licensed physician, certified physician assistant, certified nurse practitioner, certified psychologist, behavioral health specialist, treatment program counselor, treatment program administrator, probation officer or court official.)***

Name *(Print or Type)*: ______________________________

Title: ______________________________ Phone No: ______________

Signature: ______________________________ Date: ____________

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 602-542-4248; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local