

# FAMILY CAREGIVER REIMBURSEMENT PROGRAM PACKET

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**ARIZONA FAMILY CAREGIVER REIMBURSEMENT PROGRAM APPLICATION**

Starting January 1, 2021, family caregivers can be reimbursed **50% of costs for home modifications and assistive care technology up to \$1,000** for each qualifying family member. The qualified family member must be 18 years or older and requires help with one (1) or more activities of daily living. This program is first come first served.

**IMPORTANT INFORMATION**

- Applications will be reviewed on a first-come, first serve basis upon submission of application due to limited funding.
- Family caregivers are not eligible to apply for the grant again for three (3) consecutive calendar years if approved.
- For reimbursement over \$600 a 1099 tax form will be issued to the applicant and is considered taxable income.

**You will need all required documents (detailed below) at the time of submitting this application.**

Return this application to the **Arizona Caregiver Coalition**  
P. O. Box 21623 Phoenix, Arizona 85036 or email to [CRL@azcaregiver.org](mailto:CRL@azcaregiver.org) or fax 888-288-6293.

**Date of application:** \_\_\_\_\_

**Total amount requested for reimbursement (50% of qualifying expenses, up to \$1,000):** \$ \_\_\_\_\_

Describe the project or equipment purchased:

Referral Source:

Family/Friend    Physician    Hospital    Agency    Senior Center    Other \_\_\_\_\_

**FAMILY CAREGIVER INFORMATION** (*individual completing the application*)

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Phone (home, work, cell): \_\_\_\_\_

Email: \_\_\_\_\_

Arizona Resident:    Yes    No

Gender:    Male    Female    Declined to state

Race:    Asian    Black/African American    Native Hawaiian or Pacific Islander  
American Indian or Alaskan Native    White    Other    Declined to state

Ethnicity:    Hispanic or Latino    Not Hispanic or Latino    Declined to state

Preferred method of communication:    Email    Mail

Relationship to the family member:

Spouse    Child    Grandchild    Stepchild    Parent    Stepparent    Grandparent    Sibling  
Uncle or Aunt whether whole or half blood or by adoption    Domestic Partner    In-law

Length of time providing care for the family member:

Less than 1 year    1-2 years    3-5 years    6-10 years    11 or more years

How much did this home modification and/or assistive care technology help to keep your family member living at home?

Not at all    Some    A great deal    Unknown    Refuse to answer

**\* Qualified Family Member is the individual receiving care.**

**QUALIFIED FAMILY MEMBER (1)**

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Phone (home, work, cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

Arizona Resident: Yes No

Gender: Male Female Declined to state

Veteran: Yes No Declined to state

Race: Asian Black/African American Native Hawaiian or Pacific Islander  
American Indian or Alaskan Native White Other Declined to state

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to state

**Amount requested for family member (1) reimbursement (50% of qualifying expenses, up to \$1,000):**

\$ \_\_\_\_\_

**QUALIFIED FAMILY MEMBER (2)**

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Phone (home, work, cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

Arizona Resident: Yes No

Gender: Male Female Declined to state

Veteran: Yes No Declined to state

Race: Asian Black/African American Native Hawaiian or Pacific Islander  
American Indian or Alaskan Native White Other Declined to state

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to state

**Amount requested for family member (2) reimbursement (50% of qualifying expenses, up to \$1,000):**

\$ \_\_\_\_\_

## QUALIFYING EXPENSES

- Improving or altering the family caregiver's primary residence whether it be owned or rented
- Purchasing/leasing equipment or assistive care technology for the qualified family member to enable/assist/carry out one or more activities of daily living (toileting, bathing, dressing, grooming, eating, mobility, or transferring)

Examples of qualifying expenses **are not limited to this** list and include:

### Home Modification Costs

- Widening of doorways
- Ramps/low inclined walkways
- Adaptive switches
- One-bathroom environment
  - (roll-in/curb-less) accessible shower
  - roll-under sink
  - high rise toilet with handrails
  - handrails and grab bars in accessible shower

### Assistive Care Technology

- Hearing aids
- Eating: adaptive utensils, dentures
- Transferring: Hoyer lift, gait belt
- Toileting; bedside commode
- Bathing: shower chair/bench, handheld shower head
- Vehicle wheelchair lift
- Dressing assistance; buttoning aid hook, long reach comfort wipe
- Mobility: Bed handles, wheelchairs, scooters, walkers, canes
- Communication devices; voice recognition programs, screen readers, screen enlargement applications
- Monitoring systems: medical alert devices
- Computer software and hardware: voice recognition programs, screen readers, and screen enlargement applications

## EXPENSES NOT ALLOWABLE

- Regular food, clothing or transportation expenses, gifts provided to the qualified family member
- Ordinary household maintenance or repair that is not directly related to and necessary for the care of the qualified family member
- Any amount that is paid for or reimbursed by the insurance or by the federal government or state of Arizona
- Covered expenses from the qualified family member's insurance policy

**The following statements include the documents required to apply for the program. Please read the following statements and initial each blank line below.**

\_\_\_\_\_ I agree that the qualified family member and I must be 18 years or older. I will provide a copy of **one (1)** of the following for both of us:

- Arizona driver's license
- ID card (with birthdate)
- Birth certificate

\_\_\_\_\_ I agree that the qualified family member and I must be residents of Arizona.

Note: For home modifications and if renting, any construction or alteration of the residence must be authorized by the owner.

I will provide a copy of **one (1)** of the following for both of us:

- Arizona driver's license
- Utility bill
- Arizona Voter Registration Card

\_\_\_\_\_ I agree that I will need to provide proof that the qualified family member requires assistance with one or more activities of daily living (ADLs).

I will provide a signed copy of the Medical Need Verification form (provided) and signed by a Physician, Nurse Practitioner (NP) or Physician's Assistant (PA).

\_\_\_\_\_ I agree that I will provide proof of my gross income and the qualified family members gross income in the taxable year.

\_\_\_\_\_ I will provide a copy of **one (1) or more of the following for each person:**

- Income taxes
- Social Security award
- Pay stub
- Veteran Award Letter
- Any public benefit award letter (TANF, SNAP, etc.)

**Note:** The family caregiver's income in the taxable year, together with gross income of each family member may not exceed:

\$75,000 for a single person or a married person filing separately  
(caregiver + qualified family member = total gross income)

or

\$150,000 for a married couple filing a joint return  
(caregiver + spouse + qualified family member = total gross income)

\_\_\_\_\_ I understand that I am required to complete a W-9 form (provided). Please fill out completely per the W-9 Instruction Sheet.

If approved and the amount requested for reimbursement is \$600 or more, the reimbursement is then taxable. Arizona Department of Economic Security (DES) is required to provide a 1099- Misc tax form because it is a type of payment and I will need to declare the reimbursement amount as income when filing my taxes.

\_\_\_\_\_ I understand that if approved for the program, I will not be eligible to apply for the Arizona Family Caregiver Reimbursement Program for three (3) years.

\_\_\_\_\_ I understand that I will provide a copy of receipts for qualified expenses.

\_\_\_\_\_ I understand that I will complete and return the Zarit Burden Interview Questions Form with the application packet. I will also be contacted for a follow-up survey to determine whether the home modifications or purchasing/leasing of assistive care technology delayed or prevented the qualified family member from entering a long-term care facility or assisted living facility in the calendar year of the application.

My signature on this form signifies that all information provided on this form is truthful and accurate. I further acknowledge that completion of this application does not guarantee that I will be eligible for the Arizona Family Caregiver Reimbursement Program.

Print Name: \_\_\_\_\_

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

Please return this application by 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

For questions contact a Caregiver Resource Specialist at (888) 737-7494.

**MEDICAL NEED VERIFICATION**

Dear Licensed 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) during a calendar year. 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) or Physician's Assistant (PA) to verify the patient requires assistance with one or more activities of daily living (ADLs).

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 LICENSED PROFESSIONAL**

Your review and response is urgently needed. Without your timely response, 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): \_\_\_\_\_

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

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

Physician's Assistant (PA): \_\_\_\_\_

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: \_\_\_\_\_

**TO BE COMPLETED BY FAMILY CAREGIVER**

Return this form 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. For questions contact the Arizona Caregiver Coalition at (888) 737-7494.

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

**State of Arizona Substitute W-9: Request for Taxpayer Identification Number and Certification**

Submit completed form to the State of Arizona Agency with whom you are doing business with for review and authorization.

1	<b>Type of Request (Must select at least ONE)</b>		
	<input checked="" type="radio"/> New Request <input type="radio"/> New Location (Additional Address ID) <input type="radio"/> Change - Select the type(s) of change from the following:	<input type="checkbox"/> Tax ID <input type="checkbox"/> Main Address	<input type="checkbox"/> Legal Name <input type="checkbox"/> Remittance Address <input type="checkbox"/> Entity Type <input type="checkbox"/> Contact Information <input type="checkbox"/> Minority Business Indicator
2	<b>Taxpayer Identification Number (TIN) (Provide ONE Only)</b>		
	TIN <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR	SSN <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
3	<b>Entity Name</b> (As it appears on IRS EIN records, IRS Letter CP575, IRS Letter 147C or Social Security Administration Records, Social Security Card. If Individual, Sole Proprietor, Single Member LLC, enter First, Middle, Last Name.)		
	<input type="text"/> Legal Name <input type="text"/> DBA Name		
4	<b>Entity Type</b> (Must select ONE of the following)		
	<input checked="" type="radio"/> Individual/Sole Proprietor or Single-Member LLC <input type="radio"/> Corporation <input type="radio"/> Partnership <input type="radio"/> Limited Liability Company (LLC) including Corporations & Partnerships	<input type="radio"/> The US or any of its political subdivisions or instrumentalities <input type="radio"/> A state, a possession of the US, or any of their political subdivisions or instrumentalities <input type="radio"/> Other: Tax Reportable Entity <input type="radio"/> Other: Tax Exempt Entity	<b>Description</b> <input type="text"/>
5	<b>Minority Business Indicator</b> (Must select ONE of the following)		
	<input type="radio"/> Small Business <input type="radio"/> Small Business- African American <input type="radio"/> Small Business- Asian <input type="radio"/> Small Business - Hispanic <input type="radio"/> Small Business- Native American <input type="radio"/> Small Business- Other Minority <input type="radio"/> Small, Woman Owned Business <input type="radio"/> Small, Woman Owned Business- African American <input type="radio"/> Small, Woman Owned Business- Asian	<input type="radio"/> Small, Woman Owned Business- Hispanic <input type="radio"/> Small, Woman Owned Business- Native American <input type="radio"/> Small, Woman Owned Business- Other Minority <input type="radio"/> Woman Owned Business <input type="radio"/> Woman Owned Business- African American <input type="radio"/> Woman Owned Business- Asian <input type="radio"/> Woman Owned Business- Hispanic <input type="radio"/> Woman Owned Business- Native American <input type="radio"/> Woman Owned Business- Other Minority	<input type="radio"/> Minority Owned Business- African American <input type="radio"/> Minority Owned Business- Asian <input type="radio"/> Minority Owned Business- Hispanic <input type="radio"/> Minority Owned Business- Native American <input type="radio"/> Minority Owned Business- Other Minority <input type="radio"/> Non-Profit, IRC §501(c) <input type="radio"/> Non-Small, Non-Minority or Non-Woman Owned Business <input checked="" type="radio"/> Individual, Non-Business
6	<b>Veteran Owned Business</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
7	<b>Entity Address</b>		
	<b>Main Address</b> (Where tax information and general correspondence is to be mailed) <input type="text"/> Address Line 1 <input type="text"/> Address Line 2 <input type="text"/> City <input type="text"/> State <input type="text"/> Zip code	<b>Remittance Address</b> (Where payment is to be mailed) <input type="checkbox"/> Same as Main <input type="text"/> Address Line 1 <input type="text"/> Address Line 2 <input type="text"/> City <input type="text"/> State <input type="text"/> Zip code	
8	<b>Vendor Contact Information</b>		
	<input type="text"/> Name <input type="text"/> Phone <input type="text"/> Ext. <input type="text"/> Fax	<input type="text"/> Title <input type="text"/> Email	
9	<b>Exemption from Backup Withholding and FATCA Reporting:</b> Complete this section if it is applicable to you. See instructions for more details		
	<input type="text"/> Exemption Code for Backup Withholding	<input type="text"/> Exemption Code for FATCA Reporting	
0	<b>Certification</b>		
	Under penalties of perjury, I certify that: 1. The number shown on this form is my correct Taxpayer Identification Number, and 2. I am not subject to Backup Withholding because: (a) I am exempt from Backup Withholding, or (b) I have not been notified by the IRS that I am subject to Backup Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Withholding, and 3. I am a US citizen or other US person, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
	<b>Certification instructions:</b> You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.		
	<input type="text"/> Signature	<input type="text"/> Print Name	<input type="text"/> Date

**State of Arizona Substitute W-9: Request for Taxpayer  
Identification Number And Certification**

**INSTRUCTIONS ON HOW TO COMPLETE THE SUBSTITUTE W-9 FORM**

The Arizona Substitute W-9 must be completed by the family caregiver.

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<b>Section 1</b>	Select "New Request".
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<b>Section 2</b>	Enter <u>family caregiver's</u> Social Security Number (SSN). <b>Please print legibly.</b>
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<b>Section 3</b>	Enter <u>family caregiver's</u> name on the "Legal Name" line. This should be exactly as it appears on your tax forms - it is how the IRS knows you.
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<b>Section 4</b>	Entity Type - This should be "Individual/Sole Proprietor or Single-Member LLC".
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<b>Section 5</b>	Minority Business Indicator - This should be "Individual, Non-Business".
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<b>Section 6</b>	Veteran Owned Business. If Caregiver is a Veteran - check <b>YES</b> , otherwise <b>NO</b> .
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<b>Section 7</b>	Entity Address: <ul style="list-style-type: none"><li>• "Main Address" is the address where the family caregiver's IRS tax information is mailed.</li><li>• "Remittance Address" only fill this in if it is different than the "Main Address."</li></ul>
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<b>Section 8</b>	Vendor Contact Information – family caregiver will fill this in with family caregiver's Name ( <i>must match Legal Name is Section 3</i> ), Phone, and Email Address.
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<b>Section 9</b>	Leave blank. This area is not to be filled in.
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<b>Section 10</b>	Family caregiver will sign the form, print caregiver name, and fill in the date.
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The W-9 Form must be scanned/mailed to [CRL@azcaregiver.org](mailto:CRL@azcaregiver.org) or faxed back to 888-288-6293.

Please do not take a picture and send this form in, it will not be processed.

## Arizona Family Caregiver Reimbursement Program

### FREQUENTLY ASKED QUESTIONS (FAQ)

#### General Information

#### Does this program provide financial assistance to provide care for my family member?

No, the program reimburses family caregivers who pay upfront for the cost of home modifications or purchasing/leasing assistive care technology for their qualified family member.

#### Who is considered a family caregiver?

Any immediate family member who is caring for a loved one who is currently caring for an older adult, an individual living with a chronic illness or disease, and an individual living with a disability. Family caregivers can be a spouse, child, parent, in-law, stepchild, grandchild, grandparent, siblings or other relatives' caregivers including aunts and uncles.

#### How do I know if I qualify for the program?

The family caregiver must provide a copy of:

- **Receipt(s):**  
The family caregiver pays upfront (*on or after January 1, 2021*) for the cost of home modifications or purchasing/leasing assistive care technology. Receipts may be saved up throughout the year and submitted with ONE application.
- **Income:** Provide proof of income for family caregiver **AND** qualifying family member:
  - a. Income taxes
  - b. Social Security Income (SSI) award
  - c. Pay stub
  - d. Veteran Award Letter
  - e. Any public benefit award letter (TANF, SNAP, etc.)
    - Total **combined** income for family caregiver and qualified family member's income **must not exceed:**  
\$75,000/year in total income  
(Caregiver + Qualified Family Member = total income)
    - or
    - As a couple, earn less than \$150,000/year in total income  
((caregiver + spouse) + qualified family member = total income)).
- **Age:** Be 18 years or older. Provide any one of the following for family caregiver **AND** qualifying family member:
  - a. Arizona driver's license
  - b. ID card (with date of birth)
  - c. Birth certificate

- **Arizona Residency:** Family caregiver and qualified family member must be Arizona residents, provide one of the following for each person:
  - a. Arizona driver's license or identification card
  - b. Arizona Voter Registration card
  - c. Current utility bill
- **Completed W-9:**

Included with the application and required for a check to be issued to the family caregiver. Please refer to the W-9 Instructions Page. W-9 Forms that are incorrectly filled out will not be accepted and could potentially delay processing of the application.
- **Signed Medical Need Verification Form**

The form must be signed by a Physician, Nurse Practitioner (NP) or Physician's Assistant (PA) to validate assistance with one (1) or more activities of daily living requirement. The qualified family member must:

  - a. **Require assistance with one (1) or more activities of daily living** (toileting, bathing, dressing, grooming, eating, mobility, or transferring).
  - b. **Be 18 years or older.**

### **Is this program for older adults only?**

No, family caregivers who care for an adult 18 years or older can apply for the program.

### **When does the program start?**

January 1, 2021.

## **Program Qualifications**

### **Does the qualified family member have to live in the caregivers' home to qualify?**

No. However, if the reimbursement request is intended for a home modification, the alterations must be made to the caregivers' home, not the qualified family members' home.

### **There is a gross income requirement for the family caregiver and qualified family member combined. The qualified family member and I together make more than \$75,000 per year in gross income, do I qualify?**

Unfortunately, no.

### **There is a gross income requirement for the family caregiver and qualified family member combined. My spouse and I file our taxes together and combined with the qualified family member, we make more than \$150,000 per year in gross income, do we qualify?**

Unfortunately, no.

### **If I modified my home or purchased/leased assistive care technology for my family member in 2020 or earlier, do I qualify?**

No, the modifications and purchases must be in the same year as the application for reimbursement and the program starts on January 1, 2021.

## **I'm caring for my child who requires my home to be modified and/or needs assistive care technology, do I qualify?**

Yes, if the following criteria are met:

- 1) Your child is 18 years or older.
- 2) Your adult child requires assistance with one (1) or more activities of daily living (toileting, bathing, dressing, grooming, eating, mobility, or transferring). With the application, you will submit the Medical Need Verification Form (provided) that needs to be signed by a Physician, Nurse Practitioner (NP) or Physician's Assistant (PA).
- 3) You earn \$75,000/year or less or as a couple, earn less than \$150,000/year and provide proof of income with a copy of one of the following: income taxes, Social Security Income (SSI) award, pay stub, Veteran Award Letter **or** any public benefit award letter (TANF, SNAP, etc.)
- 4) You provide receipts for home modifications and/or assistive care technology.
- 5) You provide proof of your age **and** your qualified family members age with copies of your Arizona driver's license **or** ID card (with birthdate) **or** birth certificate.
- 6) You provide proof of Arizona residency with a copy of your Arizona driver's license, Arizona Voter Registration Card **or** utility bill.

## **If there are more than one person receiving care in my home, do they need to apply separately?**

No, the option to include more than one qualified family member on the application is provided on the application. All required documents including residency and income must be included for each qualifying family member. NOTE: Each qualifying family must have a Medical Need Verification Form.

## **What is considered a home modification?**

Improving or altering the family caregiver's primary residence involves making changes to the livable spaces accessible to your family member to be safe and independent.

Examples include, but **not limited** to:

- Widening of doorways
- Ramps/low inclined walkways
- Stair lift
- Adaptive switches
- One-bathroom environment
  - (roll-in/curb-less) accessible shower
  - roll-under sink
  - high rise toilet with handrails
  - handrails and grab bars in accessible shower

## What is considered assistive care technology?

Examples include, but **not limited** to:

- Hearing aids (may be for family caregiver to ease communication challenges)
- Eating: adaptive utensils, dentures
- Transferring: Hoyer lift, gait belt
- Toileting; bedside commode
- Bathing: shower chair/bench, handheld shower head
- Vehicle wheelchair lift
- Dressing assistance; buttoning aid hook, long reach comfort wipe
- Mobility: Bed handles, wheelchairs, scooters (batteries), walkers, canes
- Communication devices; voice recognition programs, screen readers, screen enlargement applications
- Monitoring systems: medical alert devices, in-home cameras, auto fall detection devices connected to cellphones/mobile phones, movement/call buttons, personal alarms – pressure alarms for w/c or beds
- Computer software and hardware: voice recognition programs, screen readers, and screen enlargement applications
- May include skin barrier creams, mattress liners, under pads, adult briefs, wipes, gloves, medication crushers/cutters, thermometers, blood pressure cuffs, etc.

## When I apply for the program, can I submit receipts for home modifications **AND** assistive care technology for reimbursement?

Yes.

## Application Process

### If a family caregiver is receiving services, can they still apply for the program?

Yes, the program is to provide reimbursement for home modifications and purchasing/leasing assistive care technology.

### How do I get an application to apply?

Contact the Arizona Caregiver Coalition's Caregiver Resource Line at (888) 737-7494 or by email at [CRL@azcaregiver.org](mailto:CRL@azcaregiver.org). You will need to pass pre-screening questions and then a Caregiver Resource Specialist will email or mail you the application package. NOTE: December 23 is the last day to request an application by mail.

### When is the deadline to apply?

December 31, 2021. ALL required documents must be postmarked, emailed, scanned or faxed on or before December 31, 2021. **No exceptions.** Note: December 23 is the last day to request an application by mail.

## **How do I submit my documents to the Arizona Caregiver Coalition?**

There are three options to submit your application information.

- 1) Scan the requested documents and email to [CRL@AZcaregiver.org](mailto:CRL@AZcaregiver.org)
- 2) Fax to 888-288-6293
- 3) Mail to Arizona Caregiver Coalition P. O. Box 21623 Phoenix, AZ 85036

## **When will I hear back about my application?**

Once your application has been received, you will receive a response within 90 days.

## **After I receive my reimbursement, is there anything else I should do?**

You will be contacted within six (6) weeks of submitting your application as a follow up about the ability to keep the qualified family member at home.

## **Can I apply again if I've been denied?**

Yes, although family caregivers are not eligible to apply for the grant again for three (3) consecutive calendar years.

## **Can I apply again if I received a reimbursement in 2020?**

Unfortunately, no. You cannot reapply for three (3) consecutive calendar years.

## **What is a 1099 form?**

An Internal Revenue Service (IRS) form.

## **Why will I receive a 1099 form?**

If the reimbursement amount is \$600 or more, it is considered a form of payment. The Arizona Department of Economic Security (DES) is required to send a 1099 form to the family caregiver as the reimbursement is taxable income.

## **What do I have to do with the 1099 form?**

Include the 1099 when filing your annual taxes.

## **More Questions**

### **What if I have more questions?**

Please contact a Caregiver Resource Specialist at (888) 737-7494 or email at [CRL@AZcaregiver.org](mailto:CRL@AZcaregiver.org).

## Arizona Family Caregiver Reimbursement Program ZARIT BURDEN INTERVIEW QUESTIONNAIRE INSTRUCTIONS

The family caregiver data collected from the Arizona Family Caregiver Reimbursement Program will enable the Department of Economic Security - Division of Aging and Adult Services (DES/DAAS) to accurately report program outcome, need, and family caregiver burden to the Arizona State Legislature.

**Please take a moment to complete this form and return along with the application packet.**

**Follow up:** You will be contacted by the Caregiver Resource Line by phone, mail or email to complete this form 6 months from the date of determination.

**Instructions:** The Zarit Burden Interview (ZBI) Questionnaire is an effective tool for many health care and social work organizations for accurately gauging caregiver burden. *The questions and answers may help you to find insight about your overall mental and physical health. It is okay to feel angry, frustrated, guilt, stress, sad, or any mixture of complicated emotions, there are caregiver support programs you may be able to access.*

**Definition:** Family caregiving burden is defined as the experience of physical, psychological, emotional, social, or financial problems due to caring responsibility for an ill family member. Caregiving burden has been shown to be associated with caregivers' depression and poor quality of life (QoL) as well as patients' poor outcomes including reduced QoL, hospitalization, and death.

1. Take a few minutes to reflect on the 12 questions on the From A: Zarit Interview Questionnaire (provided).
2. Complete the questionnaire by using the 0 to 5 scale:  
0 – Never, 1 – Rarely, 2 – Sometimes, 3 – Quite Frequently, 4 – Nearly Always.
3. Tally up each column and record on the Total for each column.
4. Score Index:  
0 – 12 little to no burden  
13 – 24 mild to moderate burden  
25 – 36 moderate to severe burden  
37 – 48 severe burden
5. You may include your name or you may choose to remain anonymous. *The questionnaire will not use your name or other identifying information during data compilation and reporting.*
6. Return completed form with the application packet.
7. You will receive a follow up call in 6 months to complete this form again.
8. Outcomes will be provided to the Arizona State Legislature.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
Division of Aging and Adult Services

**FORM A: ZARIT BURDEN INTERVIEW QUESTIONS**

*(To be completed by the caregiver)*

Indicate how often you experience the feelings listed by checking the box that best corresponds to the frequency of these feelings.

	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
1) Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?	0	1	2	3	4
2) Do you feel stressed between caring for your relative and trying to meet other responsibilities (work/family)?	0	1	2	3	4
3) Do you feel angry when you are around the relative?	0	1	2	3	4
4) Do you feel that your relative currently affects your relationship with family member or friends in a negative way?	0	1	2	3	4
5) Do you feel strained when you are around your relative?	0	1	2	3	4
6) Do you feel that your health has suffered because of your involvement with your relative?	0	1	2	3	4
7) Do you feel that you don't have as much privacy as you would like because of your relative?	0	1	2	3	4
8) Do you feel that your social life has suffered because you are caring for your relative?	0	1	2	3	4
9) Do you feel that you have lost control of your life since your relative's illness?	0	1	2	3	4
10) Do you feel uncertain about what to do about your relative?	0	1	2	3	4
11) Do you feel you should be doing more for your relative?	0	1	2	3	4
12) Do you feel you could do a better job in caring for your relative?	0	1	2	3	4

**Score Index:**

0 – 12 little to no burden

13 – 24 mild to moderate burden

25 – 36 moderate to severe burden

37 – 48 severe burden

Total for each column: \_\_\_\_\_

Total Score: \_\_\_\_\_