
RESPITE CARE ASSISTANCE PROGRAM

PHYSICIAN'S STATEMENT

From: Primary Caregiver _____

Patient _____

Address _____

City _____ State _____ Zip _____

To: Physician _____

Specialty _____ Phone _____

Address _____

City _____ State _____ Zip _____

In order to qualify for the Alzheimer's Association Respite Care Assistance Program, a diagnosis is required. **Eligibility is restricted to the following: probable Alzheimer's disease or a dementia related to one of the following: vascular (multi-infarct) disease, Binswanger's disease, Parkinson's disease, Creutzfeldt-Jacob disease, Pick's disease, Lewey Body disease and Huntington's disease.** Dementias related to other causes do not qualify. A recommendation for respite is required from the treating physician.

DIAGNOSIS _____ **DATE** _____

Do you recommend respite services for this patient? _____

If so, check as many as appropriate:

Adult Day Care Centers _____ In-home Services _____ Short-term care in a facility _____

Comments _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

Caregivers will select and make their own arrangements for services. The financial assistance for services will be a maximum of \$500/year.

Return completed form to the above address or fax number. Thanks!

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of Greater St. Louis

