alzheimer's association®

THE BRAINS BEHIND SAVING YOURS.®

Alzheimer's Association Respite Form

Please note this is a one-time request & PWD must reside with requestor

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Requestor Name: _____ **Phone Number:**_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Relationship to PWD:_____

Person with Dementia Information:

Name: _____ **Date of Diagnosis:**_____

Type of Diagnosis:_____ **(i.e. Alzheimer's disease, Vascular Dementia, etc...)**

Name of Physician who gave Dx: _____

Physician Office Name: _____ **Phone:**_____

List of Services: (*For provider suggestions please visit communityresourcefinder.org*)

☐ Home Care ☐ Adult Day Care Program ☐ Hospice ☐ Home Health Care

*All vendors must provide a W-9 and New Vendor Form

Provider Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

* The Alzheimer's Association Capital of Texas Chapter in no way endorses the quality of the service provided by a third-party agency. The preferred provider should be made aware of the 2 week payment time frame after invoice is received by the chapter. Provider will invoice directly to the Alzheimer's Association Capital of Texas Chapter for payment. No payment will be made to the requestor directly or beforehand. The Alzheimer's Association Capital of Texas Chapter will provide funding for up to $250 during one calendar year per requestor. If service fee is greater than the amount granted, requestor is responsible for the difference.

☐ ***I agree to these Terms and Conditions.***

Please Sign Here: _____ Date: _____

Please mail or fax this form to the Alzheimer's Association COT Chapter. We will email/call you when your application is approved.

Local Phone Number: 512.592.0990

Fax: 512.692.3813

alz.org®

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