TOP AID
HEALTHCARE, INC
...We never stop caring!

ALTERNATE CAREGIVER REQUEST FORM

(Must be /submitted 60 days prior to request date)

Date:_____

AFC CM:_____

AFC RN: _____

MEMBER	
Name:	MMIS:
Address:	
	Level:
Phone:	SOC:
CAREGIVER	
Name:	
Phone:	
ALTERNATE CAREGIVER	
Name:	DOB:
Address:	
Phone:	
Date of Last APE/CG Clearence Form:	Date of Last TB:
Application: ☐ Yes ☐ No	CORI: ☐ Yes ☐ No
RN POC Training completed by:	POC Date:
RN Signature:	Date:

Number of days requested: _____

VACATION DATES REQUESTED: From _____ To_____

*An AFC provider may bill for up to 14 alternative-caregiver days per member per calendar year. Any unused alternative caregiver days follow the member when changing from one AFC provider to another AFC provider (In accordance with 130 CMR 408, 419). Please note the calendar year is fiscal year meaning (JAN-DEC). Respite days may be used at any point throughout the calendar year:

*Checks are written for ALT CG and will be available the last Monday of the following month

OFFICE USE ONLY		
Manager Approval: ☐ Yes ☐ No		
_____	_____	_____
Name	Signature	Date