DISABILITY/MEDICAL CONDITION

Verification Form

Dear Medical Provider:

In order for a parent/guardian to qualify for child care assistance due to a disability, the disability must prevent them from caring for the child (ren) on a full time basis. **If applicable,** please answer the following questions to assist us in determining the applicant's eligibility.

Print Parent or Guardian Name: _____ SSN: (optional)_____

Eligibility for child care assistance based on a parent/guardian disability:

Choose one: ☐ Is permanently disabled ☐ Is temporarily disabled until _____

BRIEF DESCRIPTION OF DISABILITY:

_____

_____

Does the parent/guardian need assistance in providing full time care for the child(ren): ☐ Yes ☐ No

If yes, briefly explain how disability prevents parent/guardian from caring for the child(ren) on a full time basis:

_____

_____

_____

_____

Is temporary disability due to maternity leave: ☐ Yes ☐ No

If yes, how long is anticipated leave? _____

_____ _____

Medical Provider's Signature Date

_____ _____

Medical Provider's Name Phone

_____

Medical Provider's Address

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