

Child Care Financial Assistance Program Special Health Needs (Adult)

_____ (Applicant) has applied for subsidized child care through the Child Care Financial Assistance Program. All information included herein is considered confidential.

The applicant's signature below gives permission for this form to be shared with the Eligibility Specialists for determining child care financial assistance eligibility.

Applicant Signature _____ Date _____

This form must be completed by a Physician (MD), Physician Assistant (PA), Nurse Practitioner (NP) or state licensed Psychologist. Incomplete forms and forms filled out by other health care professionals or by the applicant will not be accepted.

The person named below has indicated that they have a physical, mental or emotional condition which precludes them from employment or training and the ability to provide the necessary care and supervision of their child(ren) during the hours specified below.

Patient Name _____

Are you currently treating this person for a condition or illness? Yes No

Diagnosis and brief explanation of why, based upon the condition, the patient is unable to care for their child(ren) during the hours specified _____

Expected duration of condition _____

Specific days and number of hours child care is necessary:

Sun _____ Mon _____ Tues _____ Weds _____ Thurs _____ Fri _____ Sat _____ Total # Hours _____

Child(ren)'s name(s) and age(s) _____

Completed by: Physician/Physician Assistant Nurse Practitioner State Licensed Psychologist

Name of health care provider _____

Address _____ Phone Number _____

Signature of health care provider _____ Date _____

The Child Development Division reserves the right to question/limit the days and hours of child care. Child care will not be authorized if another primary caretaker is available to care for her/his own children.

If you have questions regarding completion or submission of this form, please contact the Community Child Care Eligibility Specialist at the number below:

