SCHOOL READINESS PROGRAM
DISABILITY VERIFICATION FORM

To be completed by the Licensed Physician:

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 client's eligibility.

Print Parent or Guardian's Name: ____

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

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

☐ Exempt from work requirements due to age

____ ___________________________________

Licensed Physician's Signature **Date**

____ ___________________________________

Licensed Physician's Name PRINTED **Licensed Physician's Telephone Number**

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Licensed Physician's Address

RL/TW – SR Disability Verification Form 092215