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
			(D), Physician Assistant (PA), Nurse Practitioner (NP) or state ms filled out by other health care professionals or by the applicant
	have a physical, mental or emotional condition which precludes y to provide the necessary care and supervision of their child(ren)		
Patient Name			
Are you currently treating this person for a condi	tion or illness? Yes No		
Diagnosis and brief explanation of why, based up during the hours specified	oon the condition, the patient is unable to care for their child(ren)		
Expected duration of condition			
Specific days and number of hours child care is n	ecessary:		
SunMonTuesWeds	_Thurs Fri Sat Total # Hours		
Child(ren)'s name(s) and age(s)			
Completed by: Physician/Physician Assistan			
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:



Agency of Human Services