

DO NOT USE WHITE OUT OR CORRECTION TAPE.

If corrections are needed, use a new form. Alterations, word strikes or overlapped writing will make this form invalid.

VERIFICATION OF DISABILITY

Dear Physician:

To determine if your patient is eligible for subsidized child care services and exempt from work requirements due to age or disability, please assist us by completing this form in its entirety. **Return to ELCFH by:** _____

If you have any questions, please contact **Family Services** at 941-255-1650.

Client Name: _____ Date of birth: _____

I give consent to release my medical information to the **Early Learning Coalition of Florida's Heartland, Inc.** (ELCFH) to determine my eligibility for child care services.

I also give consent for this completed form to be sent directly to the ELCFH Office via: **fax to 941-255-5856 or scanning and email to:** CS@elcfh.org

Client Signature: _____ Date signed: _____

This form is to be completed by a *PHYSICIAN LICENSED under Chapter 458 or 459, F.S.*

1) Is there a medical disability? ☐ Yes ☐ No Effective date of disability: _____

2) Is this condition ☐ Permanent or ☐ Temporary?

→ If temporary,

○ please indicate the possible duration (# of months) or end date: _____

○ what is the date of the next visit at your office: _____

3) Does the disability prevent the client from being employed? Yes ☐ No ☐

4) Does this disability limit the client from caring for his/her children? Yes ☐ No ☐

→ If yes, describe the limitations: _____

5) Does this disability require child care outside of the home? Yes ☐ No ☐

→ If yes, child care services are needed:

☐ Part-time (3 to 6 hours per day) or ☐ Full-time (6 to 11 hours per day).

Clearly Printed Name of Licensed Physician

Physician's License Number

Signature of Licensed Physician

Date Form Completed & Signed

Office Address

City

State

Zip