Request for Documentation Child of Disability

Part I: To be completed by parent/guardian requesting child care services

Parent/Guardian name _____ Child's name _____

Child's: _____/_____/_____ _____-_____-_____
Date of Birth SS# (If available)

Home address _____ City _____ State _____ Zip Code _____

(_____)_____
Telephone number

Consent for release of information: I authorize the physician/psychologist named below, having records pertaining to the disability for which I am requesting subsidized child care services, to make information from such records available to ELRC of Allegheny County for the purpose of determining my eligibility for subsidized child care services for my child.

_____ _____
Parent/Guardian Signature Date

Part II: To be completed by licensed physician or psychologist

The parent/guardian above is requesting subsidized childcare services for a child over 13 years of age based on the disability of the child. Please complete all information below.

I certify that in my professional opinion, _____ requires child care services due to a medical impairment that is expected to continue until _____(month) _____(year).

Nature of the disability: ☐ Physical ☐ Behavioral ☐ Developmental

Diagnosis of present medical condition: _____

Developmental Age IN MONTHS: _____

Prognosis: Is the condition static? _____ Yes _____ No

If no, what optimum improvement can be expected? _____

_____

Physician/Psychologist Name_____

License No._____

Address: _____

Telephone Number: _____

Signature: _____

Date: _____

Updated 7/1/11