pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assessment Form

PATIENT NAME:

EARLY LEARNING RESOURCE CENTER:	EARLY LEARNING RESOURCE CENTER RECORD NUMBER:
EARLY LEARNING RESOURCE CENTER STAFF NAME & TITLE:	

SECTION ONE: Must be completed by the parent with the disability.

PLEASE PRINT CLEARLY - **Be sure to sign your name and date the form in the appropriate space below.**	
NAME (First, M.I., Last):	DATE OF BIRTH: _____/_____/ _____
ADDRESS: STREET CITY STATE ZIP CODE	

I authorize and request the disclosure to the Early Learning Resource Center (ELRC), acting on behalf of the Department of Human Services, any medical/clinical information as necessary for the ELRC to assess my eligibility for the subsidized child care program.

X _____ X _____

SIGNATURE OF PARENT WITH A DISABILITY **DATE**

A physician or psychologist must complete section two of this form.

Return the completed form to the Early Learning Resource Center listed below.

RETURN TO:

CD 878 0 6 / 1 8

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DEPARTMENT OF HUMAN SERVICES

Medical Assessment Form

PATIENT NAME:

SECTION TWO: Must be completed by a physician or psychologist.

The following information will be used by the Early Learning Resource Center to assess your patient's eligibility for subsidized child care.

1. **Diagnosis - condition causing the disability:**

2. **Is the disability permanent?** ☐ **Yes** ☐ **No**

3. **Ability to work or participate in an education or training program:**

   ☐ The patient's condition **DOES NOT PROHIBIT** him/her from working or participating in an education or training program.

   ☐ The patient's condition **DOES PROHIBIT** him/her from working or participating in an education or training program.

   How does the condition affect the patient's ability to work or participate in education or training?

4. **Expected date the inability to work or participate in an education or training program will end:** _____/_____/ _____

5. **Ability to care for the child(ren) for whom subsidy is requested:**

   Names and ages of patient's children:

   _____

   ☐ The patient's condition **DOES NOT PROHIBIT** him/her from providing care for the child(ren) for whom subsidy is requested.

   ☐ The patient's condition **DOES PROHIBIT** him/her from providing care for the child(ren) for whom subsidy is requested.

   How does the condition affect the patient's ability to provide care for the child(ren) for whom the subsidy is requested?

6. **Expected date the inability to provide care for the child(ren) for whom the subsidy is requested will end:** _____/_____/ _____

7. **The date of last examination:** _____/_____/ _____

8. **Date of next scheduled appointment:** _____/_____/ _____

PREPARED BY:	
PRINTED NAME OF PHYSICIAN OR PSYCHOLOGIST:	TITLE:
ADDRESS:	TELEPHONE: ( )_____- _____
SIGNATURE OF PHYSICIAN OR PSYCHOLOGIST:	DATE COMPLETED FORM: _____/_____/ _____

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