

| 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 | |
| | | | | |

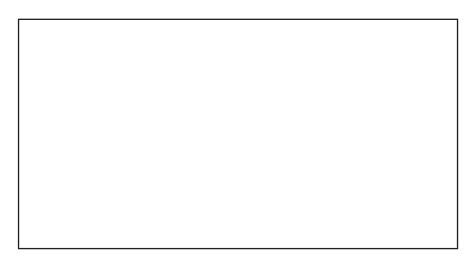
I authorize and request the disclosure to the Early Learning Resource Center (ELRC), acting on behalf of the Department of Human Services, any medical/clinical information as necessary for the ELRC to assess my eligibility for the subsidized child care program.

| Х | | Х | |
|---|---------------------------------------|---|------|
| | 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:





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: | | | |
| PRI | INTED NAME OF PHYSICIAN OR PSYCHOLOGIST: | | |
| | | | |