Physician’s Disability Statement

Date: _____/_____/_____

To Whom It May Concern:

Your patient, _____________________________________________________, is seeking child care assistance due to his/her disability. We must have the following information in order to determine eligibility for child care assistance:

This patient’s disability is considered to be:

☐ Permanent
☐ Temporary; anticipated duration: ________________________________
☐ Maternity Leave; anticipated due date: _____/_____/_____

Physician or Clinic Name, Address and phone number:

(Print or stamp)

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

I declare that the above information is true and complete; I know that if I knowingly give false information, I am liable for prosecution under state law; Further, I give my consent to Community Coordinated Care for Children, Inc., The Department of Children & Families, and The Division of Public Assistance Fraud to make inquiry into the statement made above.

________________________________________________________
Signature of Physician Date

Thank you for your assistance,

4C /Family Support Department