Date: _____/_____/

To Whom It May Concern:

Your patient, ____________________________________________, is seeking child care assistance through the School Readiness Program due to his/her disability. To determine eligibility, we must have the following information:

This patient’s disability is considered to be:
- ☐ Temporary; anticipated duration: ________________________________
- ☐ Permanent

Due to the disability, is the patient in need of child care assistance?
- ☐ Yes
- ☐ No

________________________________________________________________________

______________________________  __________________________
Signature of Physician                                                Date

Physician or Clinic Name and phone number:
(Print or stamp)
_______________________________________________
_______________________________________________
_______________________________________________

Thank you for your assistance,

School Readiness Program Eligibility Department

Effective 2.16