SCHOOL READINESS PROGRAM
PHYSICIAN'S DISABILITY STATEMENT

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