



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:



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:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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