

STATEMENT OF PARENTAL INCAPACITY

To be eligible for childcare & development services due to a physical or mental health condition preventing the parent/guardian from providing care or supervision for at least part of the day, annual verification by a licensed health professional is required.

PARENT/GUARDIAN RELEASE OF INFORMATION

To be completed by the incapacitated parent/guardian. By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized childcare and development services, I authorize and request the health professional named below to release the information requested to the agency identified below. I further authorize the health professional to discuss this Statement of Parental Incapacity with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.

NAME OF PARENT/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	DATE	
FIRST NAME AND AGE OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:			
1.	2.	3.	4.

REQUESTING AGENCY INFORMATION

AGENCY Stanislaus County Office of Education	AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	TELEPHONE NUMBER (209) 238-6300
ADDRESS 1325 H Street #005	CITY Modesto	ZIP CODE 95354

LICENSED HEALTH PROFESSIONAL STATEMENT & VERIFICATION

To be completed by the licensed health professional. For the family to be eligible to receive childcare and development services under the category of incapacity, the California law requires annual verification of the physical or mental incapacity of the parent or guardian that renders the person incapable of caring for or supervising the family's child(ren) without assistance. (*See California Code of Regulations, Title 5, §18088.*) Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.

PATIENT _____ has a physical condition or mental health condition that prevents him or her from providing care or supervision for the child(ren) listed above for at least part of the day.	Please indicate the time in a day and the days of the week, not to exceed 50 hours in a week, that the parent is unable to care for or supervise the child(ren).							
	Child care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Start Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
	End Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
	If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours ☐ and days of the week [M, T, W, T, F, S, S] that services are needed.							

NAME OF LICENSED HEALTH PROFESSIONAL	LICENSE TYPE	LICENSE NUMBER	
SIGNATURE OF LICENSED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER ()	
MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY			
ADDRESS	CITY	STATE	ZIP CODE