Case Number:

DISABILITY VERIFICATION FORM

Patient Information

Patient Name: ______________________ Patient DOB: __________

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of the requested medical/psychiatric information to the State of Connecticut's Office of Early Childhood Care 4 Kids program.

____ ___________________

Signature (in ink) of Patient or Legal Representative Date

This section to be completed by Treating Physician or Certified Mental Health Provider

Note to Provider: The family has applied for Care 4 Kids for their children. The family states that this person is unable to provide care for the children in the home because of a medical or mental impairment. Please complete the following form to verify this information. Completion of this form is necessary to determine child care assistance payments. Please return to us within 10 days.

Date of the most recent exam __________________________

Do you treat this patient for any physical or mental impairment? Yes _____ No _____

If yes, please describe the impairment on the lines below and attach any patient information.

____
____
____

Does the condition described above prevent the individual from providing safe and competent care for the child(ren) in their household? **Please take into consideration the child's age and special needs in relation to the individual's ability to provide care.**
Yes ___________ No ________

If yes, please describe the reason the condition prevents the individual from providing care.

____
____
____

What is the expected duration of the disability or impairment?

____

Is the parent taking any medication which might impair judgement? Yes ______ No _______

CC-DF
Rev. 10/18

Case Number:

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Please provide any additional information concerning the patient which may support the applicant's statement that the patient is not capable of providing care.

____
____
____

This report must be signed by a Treating Physician or Certified Mental Health Professional.

____________________________	__________	________________	_________
Health Professional Name (print)	Title	Specialty	Telephone

____________________________	_________________	__________	_________
Address	City	State	Zip Code

____________________________	___________
Signature	Date