

VERIFICATION OF DISABILITY

Dear Physician:

In order to determine if your patient is eligible for subsidized child care services and exempt from work requirements due to age or disability, please assist us by completing this form in it's entirety. **Return to ELCFH before:** _____

If you have any questions, please do not hesitate to contact: _____ at _____ / _____

Client Name: _____ **Date of Birth:** _____

I give consent to release my medical information to the Early Learning Coalition of Florida's Heartland, Inc. (ELCFH) to determine my eligibility for child care services.

Client Signature: _____ **Date:** _____

This form is to be completed by a *PHYSICIAN LICENSED under Chapter 458 or 459, F.S.*

1. Is there a medical disability? Yes No Effective date of disability: _____

2. What is the specific diagnosis of illness/injury of the client? _____

3. Is this condition Permanent or Temporary?

→ *If temporary, indicate estimated duration (# of months) or end date:* _____

→ *If temporary, what is the date of the next doctors visit?* _____

4. Does the disability prevent the client from being employed? Yes No

5. Does this disability limit the client's ability to care for his/her children full-time? Yes No

→ *If yes, describe limitations:* _____

6. Does this disability require child care outside of the home? Yes No

→ *If yes, child care services are needed:* Part-time (3-6 hours per day)

Full-time (6-11 hours per day)

Signature of Licensed Physician Date Form Completed

Print Name of Licensed Physician Physician's License Number

Mailing Address: _____ Phone Number: _____



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