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

DIVISION OF Early Learning
LEARN EARLY. LEARN FOR LIFE.

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