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