

Verification Form



Dear Medical Provider:

In order for a parent/guardian to qualify for a child care scholarship due to a disability, the disability must prevent them from caring for the child (ren) on a full time basis. **If applicable**, please answer the following questions to assist us in determining the applicant's eligibility.

Print Parent or Guardian Name: _____ SSN: (optional) _____

Eligibility for child care scholarship based on a parent/guardian disability:

Choose one: Is permanently disabled Is temporarily disabled until _____

BRIEF DESCRIPTION OF DISABILITY:

Does the parent/guardian need assistance in providing full time care for the child(ren): Yes No

If yes, briefly explain how disability prevents parent/guardian from caring for the child(ren) on a full time basis:

Is temporary disability due to maternity leave: Yes No

If yes, how long is anticipated leave? _____

Medical Provider's Signature

Date

Medical Provider's Name

Phone

Medical Provider's Address

