

4Cs, 131-A Stony Circle, Suite 300, Santa Rosa, CA 95401

Phone: 707-544-3077 Fax: 544-2625

STATEMENT OF PARENTAL INCAPACITY

PART I – To be completed by the authorized agency representative and the incapacitated parent.			
By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized child care and development services, I authorize and request the health professional named in Part II to release the information requested to the agency identified below. I further authorize the health professional to discuss this Statement of Incapacity with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.			
NAME OF PARENT/CARETAKER		SIGNATURE OF PARENT/CARETAKER	
DATE			
FIRST NAME AND AGE OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:			
1.	2.	3.	4.
AGENCY Community Child Care Council (4Cs)		AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	
		TELEPHONE NUMBER (707)544-3077	
ADDRESS 131-A Stony Circle, Suite 300		CITY Santa Rosa	ZIP CODE 95401

PART II – To be completed by the licensed health professional.								
For the family to be eligible to receive child care and development services under the category of incapacity, the California law requires verification, at least annually, of the physical or mental incapacity of the parent or caretaker that renders the person incapable of caring for or supervising the family's child(ren) without assistance. (See California Code of Regulations, Title 5, §18088.) Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.								
PATIENT _____ HAS a <input type="checkbox"/> physical condition or a <input type="checkbox"/> mental health condition that prevents him or her from providing care or supervision for the child(ren) listed above for at least part of the day.	Please indicate the time in a day and the days of the week, not to exceed 50 hours in a week, that the parent is unable to care for or supervise the child(ren).							
	Child care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Start Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
	End Time:	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm	am/ pm
PROBABLE DATES OF INCAPACITY From: _____ To: _____	If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours <input type="checkbox"/> and days of the week [M, T, W, T, F, S, S] that services are needed.							

If the parent has a physical/medical condition, please identify the extent to which the parent is incapable of providing care and supervision.

Please sign and submit this form to the agency listed in Part I within 15 days of receipt of this form.

NAME OF LICENSED HEALTH PROFESSIONAL		LICENSE TYPE	LICENSE NUMBER	
SIGNATURE OF LICENSED HEALTH PROFESSIONAL		DATE	TELEPHONE NUMBER ()	
MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY				
ADDRESS		CITY	STATE	ZIP CODE