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	AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	TELEPHONE NUMBER
Community Child Care Council of Sonoma County		(707) 544-3077

ADDRESS	CITY	ZIP CODE
131-A Stony Circle, Suite 300	Santa Rosa	95401

PART II

If the basis of need for child care and development services is parental 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 Welfare and Institutions Code, Section 10271)

☑ Patient ________________________________ has a physical or 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

CHILD CARE

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).

	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

Please sign and submit this form to the agency listed in Part I.

NAME OF LEGALLY QUALIFIED HEALTH PROFESSIONAL		LICENSE NUMBER
SIGNATURE OF LEGALLY QUALIFIED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER

MEDICAL GROUP OR ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE