MEDICAL ASSESSMENT FORM

FAMILY NAME:	CCIS AGENCY:	CCMIS ID:
CCIS STAFF:	CCIS STAFF TITLE:	

SECTION ONE: MUST BE COMPLETED BY THE PARENT WITH A DISABILITY

PLEASE PRINT CLEARLY - BE SURE TO SIGN YOUR NAME AND DATE THE FORM IN THE APPROPRIATE SPACE BELOW.

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	
ADDRESS: STREET	CITY	STATE	ZIP CODE

I authorize and request the disclosure to the Child Care Information Services (CCIS) agency, acting on behalf of the Department of Public Welfare, any medical/clinical information as necessary for the CCIS to assess my eligibility for the Child Care Works program.

SIGNATURE OF PARENT WITH A DISABILITY

DATE

A PHYSICIAN OR PSYCHOLOGIST MUST COMPLETE SECTION TWO OF THIS FORM.
RETURN THE COMPLETED FORM TO THE CCIS AGENCY OFFICE BELOW.

RETURN TO:

SECTION TWO: MUST BE COMPLETED BY A PHYSICIAN OR PSYCHOLOGIST

The information on this form will be used by the Child Care Information Services (CCIS) agency to assess your patient's eligibility for the Child Care Works program. Please indicate his or her inability to work or participate in an education or training program for a minimum of 20 hours per week **AND** inability to provide care for the child(ren) for whom subsidy is requested while the parent without a disability is working or participating in an education or training program.

1. DIAGNOSIS - CONDITION CAUSING THE DISABILITY:

2. ABILITY TO WORK OR PARTICIPATE IN TRAINING:

☐ The patient's condition **DOES NOT** prohibit him or her from working or participating in an education or training program for a minimum of 20 hours per week.

☐ The patient's condition **DOES** prohibit him or her from working or participating in an education or training program for a minimum of 20 hours per week.

HOW DOES THE CONDITION AFFECT THE PATIENT'S ABILITY TO WORK OR PARTICIPATE IN TRAINING?

3. EXPECTED DATE THE INABILITY TO WORK OR PARTICIPATE IN AN EDUCATION OR TRAINING PROGRAM FOR A MINIMUM OF 20 HOURS PER WEEK WILL END: ______________________________

4. ABILITY TO CARE FOR THE CHILD(REN) FOR WHOM SUBSIDY HAS BEEN REQUESTED:

☐ The patient's condition **DOES NOT** prohibit him or her from providing care for the child(ren) for whom subsidy has been requested.

☐ The patient's condition **DOES** prohibit him or her from providing care for the child(ren) for whom subsidy has been requested.

HOW DOES THE CONDITION AFFECT THE PATIENT'S ABILITY TO PROVIDE CARE FOR THE CHILD(REN) FOR WHOM SUBSIDY IS REQUESTED?

5. EXPECTED DATE THE INABILITY TO PROVIDE CARE FOR THE CHILD(REN) FOR WHOM SUBSIDY IS REQUESTED WILL END: ______________________________

6. DATE OF LAST EXAMINATION: ______________________________

PREPARED BY:

NAME OF PHYSICIAN OR PSYCHOLOGIST:	TITLE:
ADDRESS:	TELEPHONE:
SIGNATURE OF PHYSICIAN OR PSYCHOLOGIST:	DATE: