

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