Alameda County Pilot Program
Statement of Parent/Guardian Incapacity (01/01/18)

PART I – To be completed by the authorized agency representative and the incapacitated parent/guardian.
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/GUARDIAN	SIGNATURE OF PARENT/GUARDIAN	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
		( )

ADDRESS	CITY	ZIP CODE

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, not to exceed 24 months, of the physical or mental incapacity of the parent/guardian 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 ☐ physical condition or

a ☐ 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).

	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

If the time of day cannot be easily identified in consultation with the patient, please indicate the number of hours and days of the week that services are needed.

Hours: _____ Days: Mon Tues Wed Th Fri Sat Sun **(please circle days)**

START DATE OF INCAPACITY

If the parent/guardian has a physical/medical condition, please identify the extent to which the parent/guardian 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**