# Disability Verification Form

I, _____, give permission to release the following information to the Early Learning Coalition of Pasco and Hernando Counties for the purpose of determining my eligibility for the School Readiness program.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Printed Name SSN (optional)

**Dear Medical Provider:**

The above named individual has indicated that due to an illness or injury to him/herself or due to his/her age, he or she is unable to work or engage in other activities, and School Readiness (child care) services are needed to assist him/her in caring for his/her child(ren). **If applicable, please answer the following questions to assist us in determining the applicant's eligibility.**

## TO BE COMPLETED BY A LICENSED PHYSICIAN:

**The above named individual is (choose one):**

☐ Permanently disabled

☐ Temporarily disabled Start Date: _____ End Date: _____ (required)

**Does the disability or age of the above named individual prevent his/her participation in employment/training activities at this time?** ☐ Yes ☐ No

**Are full time child care services needed due to the illness/injury or age of the applicant?** ☐ Yes ☐ No

**Medical Provider's Signature:**_____ **Date:**_____

**Print Medical Provider's Name:**_____ **Phone Number:** _____

**Medical Provider's Office Address:**_____