

Name of Client	Client Social Security Number								
1. TO THE PHYSICIAN: The individual named above is requesting child care services due to his/her inability to provide care for his/her child(ren). Please read the following definition and complete the report. <table border="0"><tr><td>_____</td><td>_____</td></tr><tr><td>Service Worker</td><td>Date</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>Local Unit and Telephone</td><td>Address</td></tr></table>		_____	_____	Service Worker	Date	_____	_____	Local Unit and Telephone	Address
_____	_____								
Service Worker	Date								
_____	_____								
Local Unit and Telephone	Address								

2. Definition: Incapacity means any physical or mental illness, impairment or defect which is so severe as to eliminate the caretaker's ability to provide care for his/her children.

3. ☐ The client is incapacitated as stated in the definition.

What is the nature of the incapacity?

What is the anticipated duration of the incapacity?

If unknown, provide an estimated date that the condition will be reevaluated.

What are the specific restrictions that prevent the client from caring for his/her child(ren)?

What activities is the client unable to perform that prevent them from caring for his/her child(ren)?

For example but not limited to; unable to supervise, unable to diaper, dress or bathe and/or unable to prepare meals.

Examples must be age and/or special needs appropriate.

How many hours per week is the client unable to care for his/her children due to their incapacity?

☐ The client is not incapacitated.

Signature of Examining Physician (Medical Doctor)

Date

Type or Print Name of Examining Physician (Medical Doctor)

Street Address

City

State

Zip

INSTRUCTIONS TO WORKER;

This form is only completed if client is requesting child care services due to incapacity.

This form should be placed in the client's case file. No additional copies are required.