SUPPORTING PEOPLE Hastings™ AND OUR COMMUNITIES

Documentation of Parent/Guardian Special Needs

Applicant's surname	Applicant's first name
Address	Home phone #
	Cell phone #

Consent

I authorize _____ (*name of agency/doctor)* to provide the information requested on this form by Hastings County Children's Services respecting my special needs for child care services.

Parent's/Guardian's signature:	Date:

The information provided to the following questions will be used to determine eligibility/ongoing eligibility for child care services under a "special needs" category. This form must be completed by a **medical professional (MD or NP)** who is involved with this household and brought to the in-person eligibility assessment at Children's Services.

I, undersigned, certify that _____ has the following illness/disability:

_____

_____

_____

Please indicate if illness/disability is ☐ **permanent OR** ☐ **temporary**

Please fill out the required time this person is unable to care for his/her child(ren):

From _____ **To** _____
dd/mm/yy **dd/mm/yy**

Please circle the number of days per week that Child Care is recommended indicating half or full days:

1 2 3 4 5 ☐ **half-days OR** ☐ **full-days**

Name of referring professional	Title/Position
Name of referring agency	Telephone #
	Address
Signature of referring professional	Date