三藩市縣補助計劃 – 家長/監護人喪失能力聲明(01/01/18)

第I部分 – 由獲授權機構代表及喪失能力家長/監護人填寫。

為了證實本人喪失照顧家中孩童的能力(涉及家長符合托兒及發展服務的資格)，在簽署此表格後，即本人授權並要求在第II部分所列的醫護專業人員向以下獲確認機構透露所需資料。本人進一步授權該醫護專業人員與該機構討論此喪失能力聲明，以便該機構可核實、澄清，或完成相關要求。本人明白，醫護專業人員在提供以下所需資料前，他們也可自行要求本人填寫一份授權同意書。

家長/監護人姓名	家長/監護人簽名	日期

要求接受托兒財務援助之孩子名字及年齡:

1.	2.	3.	4.

機構名稱	獲授權機構代表(請以正楷填寫)	電話號碼 ( )

地址	城市	郵編

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