EARLY LEARNING COALITION
OF POLK COUNTY

FORM 100
Disability Verification

I, _____ give permission to release the following information to the Early Learning Coalition of Polk County for the purpose of determining my eligibility for the School Readiness program.

_____ _____

Parent/Guardian Print Name | Date

_____ _____

Parent/Guardian Signature | 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 PHYSICIAN LICENSED UNDER CHAPTER 458 OR 459, F.S.

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

Print Medical Provider's Name: _____ Date: _____

Medical Provider's Signature: _____ Phone Number: _____

Medical Provider's Office Address: _____