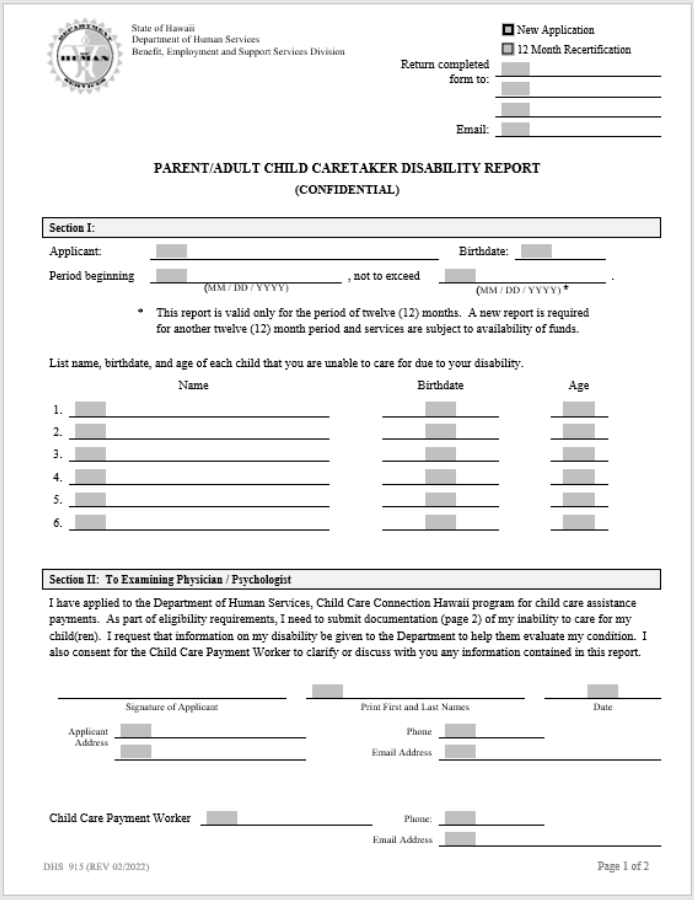
Child Care Subsidy Application
Permanent Disability
Verifications

Permanent disability - Parent/Guardian

- DHS 915 Parent/Adult Child Caretaker Disability Report or letter signed by a state-licensed physician, psychologist or psychiatrist stating disability and unable to care for own child
- Disability Income - award letter, bank statement showing deposits, checks



State of Hawaii
Department of Human Services
Benefit, Employment and Support Services Division

☐ New Application
☐ 12 Month Recertification

Return completed form to: _____
_____
_____
Email: _____

PARENT/ADULT CHILD CARETAKER DISABILITY REPORT
(CONFIDENTIAL)

Section I:

Applicant: _____ Birthdate: _____

Period beginning _____ (MM / DD / YYYY), not to exceed _____ (MM / DD / YYYY) *.

* This report is valid only for the period of twelve (12) months. A new report is required for another twelve (12) month period and services are subject to availability of funds.

List name, birthdate, and age of each child that you are unable to care for due to your disability.

	Name	Birthdate	Age
1.			
2.			
3.			
4.			
5.			
6.			

Section II: To Examining Physician / Psychologist

I have applied to the Department of Human Services, Child Care Connection Hawaii program for child care assistance payments. As part of eligibility requirements, I need to submit documentation (page 2) of my inability to care for my child(ren). I request that information on my disability be given to the Department to help them evaluate my condition. I also consent for the Child Care Payment Worker to clarify or discuss with you any information contained in this report.

_____ Signature of Applicant | _____ Print First and Last Names | _____ Date

Applicant Address: _____
_____
Phone: _____
Email Address: _____

Child Care Payment Worker _____ Phone: _____
Email Address: _____

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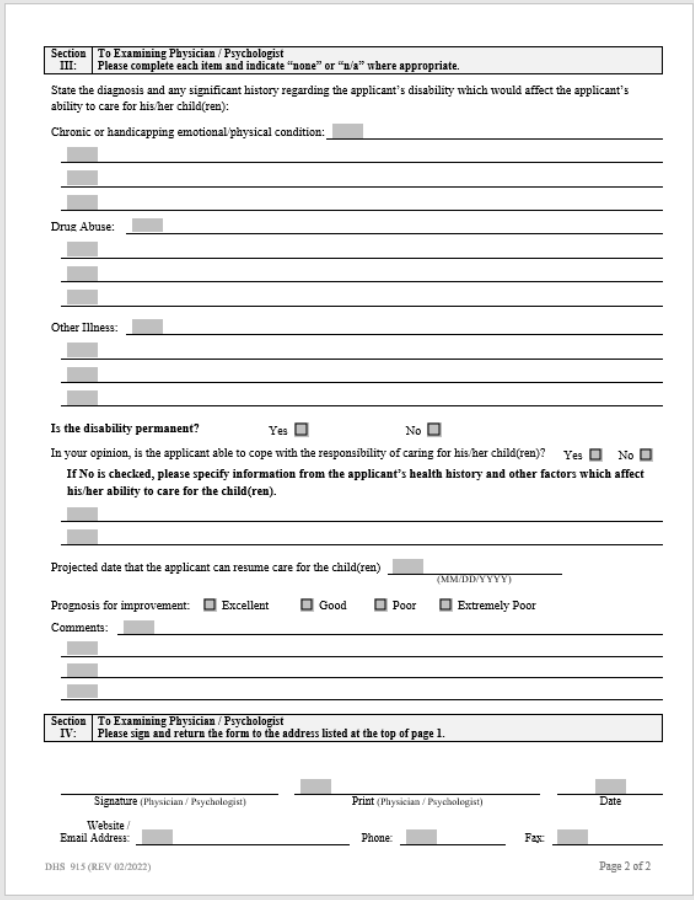

Section III: To Examining Physician / Psychologist
Please complete each item and indicate "none" or "n/a" where appropriate.

State the diagnosis and any significant history regarding the applicant's disability which would affect the applicant's ability to care for his/her child(ren):

Chronic or handicapping emotional/physical condition: _____
_____
_____
_____

Drug Abuse: _____
_____
_____
_____

Other Illness: _____
_____
_____
_____

Is the disability permanent? Yes ☐ No ☐

In your opinion, is the applicant able to cope with the responsibility of caring for his/her child(ren)? Yes ☐ No ☐

If No is checked, please specify information from the applicant's health history and other factors which affect his/her ability to care for the child(ren).

_____
_____

Projected date that the applicant can resume care for the child(ren) _____ (MM/DD/YYYY)

Prognosis for improvement: ☐ Excellent ☐ Good ☐ Poor ☐ Extremely Poor

Comments: _____
_____
_____
_____

Section IV: To Examining Physician / Psychologist
Please sign and return the form to the address listed at the top of page 1.

_____ Signature (Physician / Psychologist) | _____ Print (Physician / Psychologist) | _____ Date

Website / Email Address: _____ Phone: _____ Fax: _____

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Special Needs/disability - Children 13 through 18 years of age who cannot care for themselves

- Signed letter from a state-licensed physician, psychologist, or psychiatrist that the child 13 through 18 years has a physical or mental incapacity that prevents the child from doing self-care.
  - Child's Name
  - Child's birth date
  - Statement from a state-licensed physician or psychologist, verifying that the child has a physical or mental condition and needs child care.