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| --- | --- | --- |
|  | State of HawaiiDepartment of Human ServicesBenefit, Employment and Support Services DivisionReturn completedform to: | [ ]  New Application |
| [ ]  12 Month Recertification |
|       |
|       |
|       |
|  | Email: |       |

**PARENT/ADULT CHILD CARETAKER DISABILITY REPORT**

**(CONFIDENTIAL)**

|  |
| --- |
| **Section I:**  |
| Applicant: |  | Birthdate: |  |  |
|  |  |  |
| Period beginning |  | , not to exceed |  | . |
|  | **(**MM / DD / YYYY) |  | **(**MM / DD / YYYY) **\*** |  |
| **\*** | This report is valid only for the period of twelve (12) months. A new report is required for at least each twelve (12) month eligibility 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. |

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| --- | --- | --- | --- | --- | --- | --- |
|  | Name |  | Birthdate |  | Age |  |
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| 1. |  |  |  |  |  |  |
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| 2. |  |  |  |  |  |  |
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| 3. |  |  |  |  |  |  |
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| **Section II: To Examining Physician / Psychologist / Psychiatrist**  |
| I have applied to the Department of Human Services 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 |  | Phone |  |  |
|  | Address |  | Email Address |  |
|  |
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|  |
| Child Care Payment Worker |  | Phone: |  |  |
|  | Email Address |  |

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| --- | --- |
| **Section****III:** | **To Examining Physician / Psychologist / Psychiatrist** **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: |  |
|  |  |
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|  |
| **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: |  |
|  |  |
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| **Section IV:** | **To Examining Physician / Psychologist / Psychiatrist** **Please sign and return the form to the address listed at the top of page 1.**  |
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|  |  |  |  |  |  |
|  | Signature (Physician / Psychologist /Psychiatrist) |  | Print (Physician / Psychologist / Psychiatrist) |  | Date |
|  |

|  |  |
| --- | --- |
| Website/Email Address: |  |
|  | Phone: |  | Fax: |  |