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|  | State of Hawaii  Department of Human Services  Benefit, Employment and Support Services Division  Return completed  form to: | New Application |
| 12 Month Recertification |
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|  | Email: |  |

**PARENT/ADULT CHILD CARETAKER DISABILITY REPORT**

**(CONFIDENTIAL)**

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| **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. | | | | | |
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| 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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| **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. | | | | | | | | | |
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|  |  | | |  |  | | |  |  |
|  | 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: | | | | | | | | |  | | | | | | | | |
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| Drug Abuse: | | | |  | | | | | | | | | | | | | |
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| 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).** | | | | | | | | | | | | | | | | |
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| 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 | | |
|  | | | | | | | | | | | | | | | | | |

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