Alameda County Pilot Program
Parent/Caretaker Incapacity Documentation (REV. JAN 2022)

PART I – To be completed by the authorized agency representative and the incapacitated parent/caretaker.
By signing this form and for the purpose of verifying my incapacity to care for the family's children as it relates to the family's eligibility for subsidized child care and development services, I authorize and request the health professional named in Part II to release the information requested to the agency identified below. I further authorize the health professional to discuss this Documentation of Incapacity with the agency for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.

NAME OF PARENT/CARETAKER	SIGNATURE OF PARENT/CARETAKER	DATE

NAME AND DATE OF BIRTH OF THE CHILD(REN) FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:

1.	**2.**	**3.**	**4.**

AGENCY	AUTHORIZED AGENCY REPRESENTATIVE (Please print.)	TELEPHONE NUMBER
		( )

ADDRESS	CITY	ZIP CODE

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, California law requires a statement provided by a legally qualified health professional that the parent/caretaker is incapacitated.
"Parental Incapacity means the temporary or permanent inability of the child's parent(s) to provide care and supervision of the child(ren) for any part of the day due to a physical and/or mental health condition."
(California Code of Regulations, Title 5, §18078 & 18088)
Your cooperation in completing and returning this form to the agency listed above is requested.

Patient ____ is incapacitated, as defined by the statement above, and is incapable of providing care or supervision for the child(ren) listed above for 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/caretaker 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)**

Please sign and return this form to the agency listed in Part I.

NAME OF LICENSED HEALTH PROFESSIONAL	LICENSE TYPE	LICENSE NUMBER
SIGNATURE OF LICENSED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER ( )

MEDICAL GROUP OR HEALTH ORGANIZATION WITH WHICH THE PROFESSIONAL IS AFFILIATED, IF ANY

ADDRESS	CITY	STATE	ZIP CODE