

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**  
**SUBSIDIZED CHILD CARE**  
**VERIFICATION OF DISABILITY/SPECIAL NEED OF PARENT**

The Department of Early Education and Care (EEC) is the Lead Agency in the Commonwealth responsible for administering the Child Care Development Fund (CCDF), which is a federal block grant that provides financial assistance to low-income, working families seeking high quality early education and out of school time care programs in Massachusetts.<sup>1</sup> **Child care financial assistance funded by CCDF is not an entitlement.**<sup>2</sup> **CCDF funded child care will not be authorized for purposes of providing respite care** (e.g. to give a parent time off from parenting).<sup>3</sup>

Financial Assistance for child care may be provided to Massachusetts families that meet EEC's income eligibility criteria and confirm that they are participating in an approved service activity of employment, education and/or training. On a case by case basis, financial assistance for early education and care programs may be available to a child whose Parent has a documented disability/special need because the child is receiving or at risk of receiving protective services based on the Parent being: (1) **unable** to work or **unable** to participate in educational and/or training program; and (2) unable to provide a safe environment for the care of his/her child(ren) due to his/her disability/special need. Consideration may also be made for a Parent who is providing full time care for a child with a disability/special need, thereby necessitating care for his/her other child(ren); in such circumstances, the Parent shall request a variance, in accordance with EEC policy.

The purpose of this verification form is threefold (1) to verify the existence of the disability/special need of the Parent; (2) to explain how the disability/special need prevents the Parent from working or participating in another EEC approved activity; and (3) to explain how the disability/special need impacts the Parent's ability to provide a safe environment for the care of his/her child(ren), taking into consideration the ages and needs of the child(ren). **Please note:** Parents with a documented physical or mental disability/special need may not be authorized for more than **two years** of child care. Eligibility based upon disability/special need of parent beyond two years must be approved in writing by EEC.

**SECTION I: DISABILITY/SPECIAL NEEDS VERIFICATION**  
**(to be completed by the professional)**

The individual identified below has stated that s/he is **unable** to participate in an EEC approved service need activity such as work, school or training because of his/her disability/special need. S/he has requested EEC provide financial assistance to enroll his/her child(ren) in an early education and care program because s/he is unable to work and is unable to provide a safe environment for the care of his/her child(ren). Please fill out the information below to help us determine how we might best meet the needs of this family.

**Who may fill out this form:**

- If the disability/special need results from a physical health issue, this form must be filled out by a licensed Physician, Physician's Assistant, or Nurse Practitioner.
- If the disability/special need results from an emotional or mental health issue, this form may be filled out by a currently licensed (1) Psychiatrist, (2) doctorate level Psychologist,, or (3) Psychiatric Nurse.

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<sup>1</sup> See G.L. c. 15D, § 2.

<sup>2</sup> See 42 U.S.C. 9858(d)(a).

<sup>3</sup> See 45 CFR 98.20.

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1. Your professional role (*check one – only professionals in roles listed here may complete this verification form*):

- Physician                       Psychiatrist                       Psychologist  
 Nurse Practitioner       Psychiatric Nurse               Physician's Assistant

2. Name of Parent: \_\_\_\_\_ Date of Birth \_\_\_\_\_

3. Full name(s) of child(ren), including date(s) of birth:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Nature of **PARENT'S** special need(s)/disability (*check all that apply*):

- Physical disability/special need;  
 Mental health disability/special need; or  
 Other disability/special need.

5. How long have you been treating this individual? \_\_\_\_\_

6. How frequently do you see this individual:

- daily    weekly    monthly    other (specify frequency) \_\_\_\_\_

7. How does the disability/special need impact his/her ability to care for the child(ren) needing access to an early education and care program? {Check all that apply}

- Parent is in treatment during the day: \_\_\_\_\_ days/week and \_\_\_\_\_ hours/day;  
 Parent's special need/disability prevents the provision of a safe environment during the day;  
or  
 Other \_\_\_\_\_

8. Please state the approximate date that the disability/special need commenced:

\_\_\_\_\_ AND indicate the likely duration of the condition:

- Permanent    At least 1 year, but not permanent    6 months to 1 year    6 months or less

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9. Required Documentation to be attached to this verification form:

- A letter on official letterhead of the health professional completing this form providing specific information about the disability/special need. This letter must include a response to ALL of the following:
- identification of your patient's disability/special need;
  - explanation of how the condition prevents your patient from working or participating in education or training programs;
  - explanation of how your patient's disability/special need impacts his/her ability to provide a **safe environment** for the care of his/her child(ren) for any portion of the day, taking into consideration the age(s) and needs of the child(ren), and identify who is caring for the child for the remaining portion of the day when the child is not in subsidized care.
  - the amount of time child care is needed to accommodate the disability/special need and/or to provide a safe environment for his/her children, including the number of days per week and hours per day that early education and care services are needed.

Signature of professional: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

License number: \_\_\_\_\_

*This form must be completed in full. Please note you may be contacted by an EEC representative to verify this information. EEC reserves the right to deny or reject a claim of disability/special need if the verification form and/or its required attachments are incomplete or deemed inadequate. If you have any questions or concerns, please contact the EEC Financial Assistance Unit at 617-988-6600.*

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**SECTION II: MEDICAL RECORDS RELEASE (to be completed by the parent/Caregiver)**

**I am requesting financial assistance** for child care based on my disability/special need. I authorize the professional identified in Section I to release the information requested on this form and I also authorize the professional to share medical records or other information about my disability and/or special need listed in Section I with the EEC in order to determine eligibility for child care financial assistance. I further authorize the EEC to contact the professional identified in Section I to verify the information provided on this form and to discuss his/her diagnosis of my disability and/or special need **as it applies to the need for early education and care services.**

This form authorizes the professional to release most medical or health information with the following exception(s). The professional identified in Section I cannot disclose the following medical or health

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information, unless such disclosure is authorized. Please check the box next to each item below if you specifically authorize the professional to share the information described therein.

- I authorize the professional identified in Section I to share information about AIDS/HIV status.
- I authorize the professional identified in Section I to share information about drug or alcohol use.
- I authorize the professional identified in Section I to share information about psychological/psychiatric disorders.

I understand that this medical records release is valid for one year from the date signed below, unless I have cancelled the release in writing prior to its expiration.

I understand that I may cancel this medical records release at any time by sending a letter to the professional identified in Section I.

I also understand that, even if I cancel this release, the professional cannot take back any information that s/he has shared with EEC when s/he had the authorization to do so.

Furthermore, I understand that my decision to authorize the professional identified in Section I to share medical information with EEC is voluntary. However, I understand that if I do not authorize the professional to share medical information with EEC, a determination regarding my disability and/or special need cannot be made and my child's eligibility for child care financial assistance will be decided without consideration of my disability/special need. I understand that EEC may deny or reject my claim of disability/special need if the verification form and/or its required attachments are incomplete or deemed inadequate.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print**

Parent's name: \_\_\_\_\_ Child's name & age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Second Parent \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ Phone: \_\_\_\_\_

**THIS FORM MUST BE RETURNED TO EEC. IT IS ALSO ADVISED THAT THE MEDICAL PROFESSIONAL AND THE PARENT KEEP A COPY OF THIS FORM FOR HIS/HER OWN FILES.**

This form **MUST** be returned to:  
  
The Financial Assistance Unit  
Department of Early Education and Care  
51 Sleeper Street  
Boston, MA 02210  
or by faxing to 617-988-2451