CALIFORNIA DEPARTMENT OF EDUCATION
Child Development Division
Form CD-9606, (Rev. June 2008)

NOTE: When applicable, this form is to be completed and used with form, CD-9600.

STATEMENT OF PARENTAL INCAPACITY

Please print or type information.

PART I – To be completed by the authorized agency representative and the incapacitated parent.
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 Statement of Incapacity with the agency in order 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

FIRST NAME AND AGE 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
Stanislaus County Office of Education		(209) 238-6300

ADDRESS	CITY	ZIP CODE
1324 Celeste Drive	Modesto	95355

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, the California law requires verification, at least annually, of the physical or mental incapacity of the parent or caretaker that renders the person incapable of caring for or supervising the family's child(ren) without assistance. *(See California Code of Regulations, Title 5, §18088.)* Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.

PATIENT _____ HAS

a ☐ physical condition or

a ☐ mental health condition

that prevents him or her from providing care or supervision for the child(ren) listed above for at least 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 is unable to care for or supervise the child(ren).

Child care	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

PROBABLY DATES OF INCAPACITY

From: To:

If the time of day cannot be easily identified in consultation with the patient, please identify the number of hours ☐ and days of the week [M, T, W, T, F, S, S] that services are needed.

If the parent has a physical/medical condition, please identify the extent to which the parent is incapable of providing care and supervision.

Please sign and submit this form to the agency listed in Part I within 15 days of receipt of this form.

NAME OF LICENSED HEALTH PROFESSIONAL	LICENSE TYPE	LICENSE NUMBER

SIGNATURE OF LICENSED HEALTH PROFESSIONAL	DATE	TELEPHONE NUMBER
		( )

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

ADDRESS	CITY	STATE	ZIP CODE