

Verification Form



Dear Medical Provider:

In order for a parent/guardian to qualify for a child care scholarship due to a disability, the disability must prevent them from caring for the child (ren) on a full time basis. **If applicable**, please answer the following questions to assist us in determining the applicant’s eligibility.

Print Parent or Guardian Name: _____ SSN: (optional) _____

Eligibility for child care scholarship based on a parent/guardian disability:

- Choose one:
- Is permanently disabled Is temporarily disabled until _____
 - Is temporary disability due to maternity leave: Yes No
 - Is exempt from work requirement due to age: Yes No

I certify that under the penalty of perjury (a first degree misdemeanor punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding \$1,000 pursuant to s. 837.012, or 775.082, or 775.083, F.S.) the information given above is true and complete. I understand that it is against the law to give false information that will enable a person to receive services they are not eligible to receive. I understand that if it is discovered that I have not been truthful with this information that I may be prosecuted for fraud.

Medical Provider’s Signature

Date

Medical Provider’s Name

Phone

Medical Provider’s Address

