Case # _____

HoH MCI # _____

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

CHILD CARE MEDICAL CERTIFICATION FORM

Client Name and Address

_____

_____

_____

DSS Office Address

_____

_____

_____

List the name and age of the child(ren) needing child care.

Name	Age

Name	Age

Client's Signature: _____ Date: _____

This section must be completed and signed by a medical professional.

1) Patient Name: _____ Examination Date: _____
2) Diagnosis: _____
3) If pregnant, what is the due date? _____
4) If the patient is a parent or caretaker, does the diagnosis substantially reduce his/her ability to care for the child(ren)?
   ☐ Yes ☐ No If yes, for how long? _____
5) Is the patient able to work? ☐ Yes ☐ No
6) Is the patient between 13-18 and unable to care for him/herself due to his/her diagnosis?
   ☐ Yes ☐ No If yes, for how long? _____
7) If child care is needed due to a medical condition, how much care is needed?
   ☐ Part-time (up to 4 hours) ☐ Full-time (over 4 and up to 10 hours) Number of days per week _____
8) Does the incapacity of the patient named above require the presence of another individual in the home to care for him/her? ☐ Yes ☐ No
9) Remarks: _____

_____

_____

Medical Professional's Name (Please Print): _____

Title: _____ Phone: _____

Medical Agency or Practice: _____

Signature: _____ Date: _____