Office Use Only

CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office

HEALTH STATUS REPORT

First and Last Name of Individual Seeking Evaluation:_____

ICCIS ID Number, if known:_____

HEALTH CARE/MENTAL HEALTH CARE PROFESSIONAL: The Child Care Assistance Program (CCAP) provides financial assistance with child care expenses to help adults maintain employment so their family can be self-sufficient. A requirement of CCAP participation is that parents must participate in an eligible activity of work or in a job training or educational program to receive assistance, unless one or both parents have been determined, by a health care or mental health care professional, to be incapacitated. For CCAP purposes, incapacitated means "physically incapable of caring for children in the family, or temporarily unable to participate in an eligible activity, as determined by a health care or mental health care professional" 7 AAC 41.360(d).

The person named above has reported being incapacitated. Please evaluate this person's capacity to participate in an eligible activity of work, job training, or educational program and their capacity to care for children in their family. This information is needed to determine the family's eligibility to participate in the CCAP.

Date of Examination:_____ Diagnosis/Condition:_____

1. How long do you expect the condition to last (provide an end date)? _____
2. Is the patient taking medications that could hinder their capacity to participate in an eligible activity or care for the children in their family? ☐ Yes ☐ No
3. Can the patient work or attend a job training or education program full-time ☐ Yes ☐ No
4. Can the patient work or attend a job training or education program part-time ☐ Yes ☐ No
5. If patient can work or attend a job training or education program full-time or part-time, how many hours per day and how many days per week? _____
6. Can the patient provide care for the children of their family even if limited? ☐ Yes ☐ NoIf yes, how many hours per day and how many days per week: _____

_____
Printed Name of Health Care/Mental Health Care Professional

_____
Signature of Heath Care/Mental Health Care Professional

Date:_____ Contact Phone:_____

Address:_____