



State of New Jersey
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF FAMILY DEVELOPMENT
 CHILD CARE SUBSIDY PROGRAM

Child Verification Form

Part 1: Completed by Parent

Name of Child: _____	Date of Birth: ____ / ____ / ____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
<u>CONSENT TO RELEASE INFORMATION</u>	
I authorize the licensed health professional listed below to share information about my child's condition with the Child Care Resource and Referral Agency (CCR&R). I understand that this form will only be used for verification purposes for the New Jersey Child Care Subsidy Program. I understand that if circumstances regarding my child's condition change, I must immediately notify my CCR&R.	
Name of Parent: _____ please print	
Parent Signature: _____	Date: ____ / ____ / ____

PART 2: Completed by a Licensed Health Professional

INSTRUCTIONS: Please provide the information below to help us determine how we might meet the needs of this family. You may be contacted by the agency listed to verify this information.

Licensed Health Professional Name: _____ please print	
Licensed Health Professional Title: _____	License/Credential No: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Email: _____	Phone: _____ Fax: _____
<u>NOTICE TO LICENSED HEALTH PROFESSIONAL</u>	
By signing, I certify that the above named child has a documented medical or physical impairment which reduces his or her ability to function independently. This child requires the personal services of a caretaker to maintain his or her basic level of functioning in an age-appropriate manner. The information provided is true and accurate to the best of my understanding.	
List Child Disability: _____	
Licensed Health Professional Signature: _____	Date: ____ / ____ / ____

CCR&R USE ONLY

CCR&R Name/Address: _____	
CCR&R Representative Signature: _____	Date: ____ / ____ / ____