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: _____

CONSENT TO RELEASE INFORMATION

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: _____

NOTICE TO LICENSED HEALTH PROFESSIONAL

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: ___/___/___