CHILD CARE ASSISTANCE PROGRAM

Division of Public Assistance
Child Care Program Office
http://dhss.alaska.gov/dpa/Pages/ccare

Office Use Only

HEALTH STATUS REPORT

First and Last Name of Individual Seeking Evaluation	ICCIS Case 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 find and 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 participation 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, school, or training; or to care for children in the family. This information is needed to determine the family's eligibility to participate in the CCAP.

Date of examination:

1. Does the patient have a physical or mental health condition which limits their ability to:
   Work full time ☐ Yes ☐ No or Work part time ☐ Yes ☐ No
   If patient can work part-time, how many hours per day?
   If the condition is temporary, how long do you expect the condition to limit the patient's ability to work?

   Attend job training or educational program full time ☐ Yes ☐ No or Attend job training or educational program part time ☐ Yes ☐ No
   If patient can attend job training or an educational program part-time, how many hours per day?
   If the condition is temporary, how long do you expect the condition to limit the patient's ability to attend job training or an educational program?

   Provide care for the children of the family full time? ☐ Yes ☐ No or provide care for the children of the family part time ☐ Yes ☐ No
   If patient can care for the children of the family part-time, how many hours per day?
   If the condition is temporary, how long do you expect the condition to limit the patient's ability to care for the children of the family?

2. Is the patient taking any medications that may cause side effects impacting their ability to participate in a work, Job training or educational program environment, or to provide care for the children of the family? ☐ Yes ☐ No

Printed Name of Health Care/Mental Health Care Professional	Address
Health Care/Mental Health Care Professional Signature	Date Contact Phone

Please fax the completed form to the number indicated below.

Child Care Assistance Program Representative Job Title Fax Number