



**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_