Family, Friend & Neighbor
Child Care
Statement of Health

Name: _____

Please check one of the boxes below:

- ☐ I am applying to be the child care provider.
- ☐ I am the spouse of the applicant.
- ☐ I am a member of the applicant's household.

Applicants and household members must meet certain health requirements. As the agency responsible for approving payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

I attest that I have no disabling chronic conditions; physical, mental, or emotional illness that would prohibit me from providing care to children.

COMMENTS:

_____

Signature/Date