Special Needs Rate Request Form

To receive a special needs rate, in addition to the base rate, it must be requested by the provider and approved by the coalition. A special needs rate may be reimbursed for a school readiness child that has a documented physical, mental, emotional, or behavioral condition that requires a higher level of care in the child care setting. The child's condition must be validated by a licensed health, mental health, education or social service professional other than the child's parent/guardian or person employed by the child care provider.

By completing this form, I am applying to receive a Special Needs Rate for the child listed below.

Is this child currently receiving School Readiness (SR) services at your location?

- ☐ Yes - if you checked yes, continue to Part 1
- ☐ No – if you checked no, please refer to underlined statement above

Part 1
(Provider Use Only)

1. Child's Full Name (First and Last)	2. Child's Date of Birth	3. Days and hours of attendance a. Su M T W Th Fr Sat From: _____ To: _____
4. Parent/Guardian Name (First and Last)	5. Daytime Telephone	6. Additional Contact Info (phone/email)
7. Provider's Name		
8. Provider's Location Address		9. Provider's Contact Number _____ 10. Email Address _____
11. Name of Person Completing Form		12. Title/Position

13. Records of evaluation, supports and or services with qualifying service dates

- ☐ IEP, ILP, IFSP with service date (must be included)

Choose any additional that apply

- ☐ Therapy screening and or Agency Plan
- ☐ Vision/hearing screening
- ☐ Alternate program attendance _____
- ☐ Other _____

14. Provider special needs supports

Must Complete All

- ☐ Special needs consult questions below
- ☐ Provider Service Plan implemented to support child's special needs
- ☐ Daily schedule and/or lesson plan for child with special needs

15. Please write in detail the special needs of and the additional services you are providing to the child (development, speech language, medical, behavior and or social emotional development, etc.). If more space is needed, please attach an additional page.

16. The provider/school certifies that the information listed above is correct and has been completed to the best of my knowledge. I also certify that I am providing special needs services to the child listed above and that the required documentation has been submitted with this application.		17. I certify that my child is receiving SR services with this provider at the location listed above. I am aware of and approve the submission of this application by the provider. I fully understand that the provider is applying to receive supplementary funding to help provide additional special needs services for my child.	
18. Signature of Provider/School	19. Date	20. Signature of Parent/Guardian	21. Date

Special Needs Rate Request Form

Part 2
Official Use Only- Coalition staff must complete all boxes

☐ Receipt of Reimbursement Application with Appropriate Documentation	Date of Receipt:
Inclusion Specialist Follow-up with Applicable Matrix Level Rating (AMLR) ☐ Level One ☐ Level 2 ☐ Level Three ☐ Does Not Qualify (DNQ)	Date of Follow-up:
Records of evaluation, supports and or services with qualifying service dates received ☐ IEP, ILP, IFSP with service date ☐ Therapy screening and or Agency Plan ☐ Vision/hearing screening ☐ Alternate program attendance ________________________ ☐ Other ____	Provider special needs supports verified ☐ Special needs consult questions below ☐ Provider Service Plan implemented to support child's special needs ☐ Daily schedule and/or lesson plan for child with special needs
☐ Approved __________ ☐ Denied __________ ☐ Pending __________ Explanation of Denial/Pending ____ ____ ____ ____ ____ ____	If Approved, Initial Dates Authorized (based on IEP or qualifying service dates) From: ____________ to ____________

Approved Reimbursement Rate: $______/day

Signature of Inclusion Specialist	Date	Signature of Coalition CEO or Designee	Date

4C Notification Date:________________
Parent Certificate Copy Received from 4C: ________________________
Provider Notification Date: ______________________

Eligibility Renewal Dates: From: _________ to ________ End of Service Notification Date: __________________	Redetermination Review Date: ______________________ ☐ Level One ☐ Level 2 ☐ Level Three ☐ (DNQ) Authorizing Agent _______________________________
Eligibility Renewal Dates: From: _________ to ________ End of Service Notification Date: __________________	Redetermination Review Date: ______________________ ☐ Level One ☐ Level 2 ☐ Level Three ☐ (DNQ) Authorizing Agent _______________________________
Eligibility Renewal Dates: From: _________ to ________ End of Service Notification Date: __________________	Redetermination Review Date: ______________________ ☐ Level One ☐ Level 2 ☐ Level Three ☐ (DNQ) Authorizing Agent _______________________________
Eligibility Renewal Dates: From: _________ to ________ End of Service Notification Date: __________________	Redetermination Review Date: ______________________ ☐ Level One ☐ Level 2 ☐ Level Three ☐ (DNQ) Authorizing Agent _______________________________
Eligibility Renewal Dates: From: _________ to ________ End of Service Notification Date: __________________	Redetermination Review Date: ______________________ ☐ Level One ☐ Level 2 ☐ Level Three ☐ (DNQ) Authorizing Agent _______________________________