	Maryland State Department of Education/Office of Child Care Child Care Scholarship Program **SPECIAL NEEDS RATE REQUEST FORM**	**To Return:** Upload to the CCS Family Portal at: https://family.childcareportals.org

INSTRUCTIONS:

1. The parent/caretaker completes Sections 1 and 3.
2. The parent then takes the form to the child care program. The provider completes Sections 2, 3, 4, 4a (if applicable) and Part V.
3. The parent/caretaker is responsible for retrieving the form from the child care provider and having a licensed physician or licensed psychologist to complete Section 5 Parts I-IV (Parts 3 and 4 must be signed).
4. Once completed, the entire form is returned to the Child Care Scholarship Central 2 (CCS2) by the parent. Section 5 is confidential and may not be released once it is completed. Therefore, the parent is responsible for making a copy of the documentation prior to uploading and submitting the form to CCS2.

Section 1 PARENT/CARETAKER COMPLETES	
Name of Child with a Disability	Child's (DOB)
First Name:	Last Name:
Party ID	Parent's CCATS ID
Email Address:	Contact Phone Number:

Mailing Address: Street | City | State | Zip Code

RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE CHILD CARE SUBSIDY PROGRAM TO VERIFY INFORMATION REGARDING MY APPLICATION AND TO OBTAIN OTHER DOCUMENTATION TO ESTABLISH MY ELIGIBILITY FOR A RATE ADJUSTMENT FOR SPECIAL ACCOMMODATIONS PROVIDED TO:

______________________________.
(Child's Name)

I FURTHER AUTHORIZE RELEASE OF MEDICAL AND/OR MENTAL HEALTH INFORMATION FROM:

____
(Physician's or psychologist's name)

TO THE CHILD CARE SCHOLARSHIP PROGRAM:

______________________________ ______________________________
Parent's/Caretaker's signature Date

Section 2 PROVIDER COMPLETES	
Child's Scholarship Number:	Child's Weekly Tuition Rate as Charged by the Provider: $
Provider's First and Last Name:	Name of Child Care Program:
Provider's Email Address:	Provider's Phone Number:
Provider's CCATS ID:	Provider's License #:

Physical Address of Child Care Program:
Street | City | State | Zip Code

______________________________ ______________________________
Provider's Signature Date

Section 3 PARENT & PROVIDER COMPLETES

FRAUD STATEMENT

Directions: Parent and provider must read and sign.

This application gives the Maryland State Department of Education, Office of Child Care information about whether the parent is eligible for an increase in the payment received under the Child Care Scholarship (CCS) program. It also gives us information about the special accommodations made by the provider to care for a child. The funds to pay for this increased cost are provided at public expense so the provider and parent must give true information. It may be verified with public and private agencies and businesses. If you knowingly give false information, you may be subject to the penalties listed below. Additionally, your signature below is an acknowledgement of understanding that the availability of the child care scholarship payment adjustment for a child with a disability is subject to available funds and programmatic changes.

Article 27, 230A Section 8-504 of the Criminal Law Article of the Annotated Code of Maryland states that:

(a) Any person who fraudulently obtains, attempts to obtain, or aids another person in fraudulently obtaining or attempting to obtain money, property, food stamps, medical care, or other assistance to which he or she is not entitled, under a social, health, or nutritional program based on need, financed in whole or in part by the State of Maryland, and administered by the State or its political subdivisions is guilty of a misdemeanor. For purposes of this section, fraud shall include:

(1) willfully making a false statement or representation; or
(2) willfully failing to disclose a material change in household or financial condition; or
(3) impersonating another person.

(b) Upon conviction, after notice and the opportunity to be heard as to the amount of payment and how the payment is to be made, the person shall make full restitution of the money, property, food stamps, medical care or other assistance unlawfully received, of the value thereof, and shall be fined not more than $1,000 or imprisoned for not more than three years, or both fined and imprisoned.

Parent's/Caretaker's Signature ____________________ Date __________

Provider's Signature ____________________ Date __________

Section 4 PROVIDER COMPLETES

Directions: The provider must complete this section identifying the service provided that is beyond reasonable accommodations and specifying the cost for the service. This portion of Section IV must be shared with the parent/caretaker.

A. The provider's justification for a rate adjustment is based on the following extra cost(s):

Column I	Column II	Column III	Column IV
Accommodation	**Expenses**	**Cost Per Day**	**Cost Per Month**
*Equipment or Special Apparatus purchase	$_____	_____	_____
Equipment rental	$_____	_____	_____
Increased utility cost due to machinery	$_____	_____	_____
*Special transportation	$_____	_____	_____
**Additional staff-individual attention including for physical activity	$_____	_____	_____
*Environmental modification resulting in limiting capacity of the program	$_____	_____	_____
Therapeutic materials	$_____	_____	_____
Other	$_____	_____	_____
Total	**$_____**		

Provider's Signature Date

I have reviewed the above provided service(s) supplied to my child by the provider named above. I understand that my child's provider is requesting additional payment because these services are being provided for my child.

Parent's/Caretaker's Signature Date

B. Supply the information listed below regarding your financial resources to help us determine if the services listed above would be an undue burden on your program without a rate adjustment. This portion of the Section IV should be returned to the CCS Central by the provider. The information is confidential and may not be released. Therefore, make a copy of the documentation prior to submission.

1. Number of children in your program: _____
2. Number of staff you employ: _____
3. Budget for staff salaries including all administrative staff (i.e., director)

4. Comments: Use this space to provide additional information if the services needed to accommodate _____ would result in an undue burden, or if the services are not readily achievable, or if the services would fundamentally change the nature of your program. (Attach an additional sheet, if needed)

***REIMBURSMENT WILL BE IN THE FORM OF A LUMP SUM PAYMENT. PROOF OF PURCHASE OR PAYMENT WILL BE REQUESTED. THE MARYLAND CCS PROGRAM RESERVES THE RIGHT TO REQUIRE DOCUMENTATION OF ANY INFORMATION SUBMITTED. **FOR THE HIRING OF STAFF, THE PROGRAM MUST COMPLETE & SUBMIT SECTION 4a.**

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Section 4a - Child Care Provider Completes, if funding is to hire additional staff

Directions: This section is specific to requests for additional staffing and must be complete by the Child Care Provider.

Name of Additional Staff	Hire Date (XX/XX/XXXX)	Hourly Salary	Number of Scheduled Hours Each Week	Criminal Background Check Clearance Complete? Y/N	Child Protective Service Clearance Complete? Y/N	All Licensing Clearances Complete? Y/N	Is the Staff Member an Associated Party of the Provider's Record? Y/N

Child Care Provider Acknowledgement:

By signing this document, I understand, confirm, and agree to the following statements:

1. The additional staff member works solely with the child outlined in this form.
2. The additional staff member is an employee of the child care program and not the State of Maryland.
3. I will provide the Child Care Scholarship (CCS) Program verification of payment every quarter throughout the child's enrollment and while the child has active scholarships. The verification of payment is due by:
   - January 15th,
   - April 15th,
   - July 15th and
   - October 15th each calendar year.
4. I agree to report the staff member's end date immediately, however, no later than 5 calendar days after the staff member's leave.
5. I agree to report the child's enrollment termination immediately, however, no later than 5 calendars after the child's leave.

Child Care Provider's Signature

Child Care Provider's Print Name

Date (XX/XX/XXXX)

Section 5 - **LICENSED PHYSICIAN OR LICENSED PSYCHOLOGIST COMPLETES**

Disability Certification

Dear Licensed Physician or Licensed Psychologist:

The Maryland Child Care Scholarship Program is requesting your assistance in certifying the degree of disability for ______________________ in order to consider costs incurred by a child care provider in caring for the named child. Please complete Section V parts I-IV based on your professional knowledge of the child above. **Part III and IV must be signed by a licensed physician or psychologist only.**

PART I

Child's Name: ______________________ Date of Birth: __________

Address: ______________________ Telephone #: __________
(Apartment Number, street name and number)

City: ______________________ County: __________

State: ______________________ Zip Code: __________

PART II

1. Diagnosis: ______________________
2. Prognosis: ______________________
3. Circle one: This condition is considered a mental or physical disability.
4. Circle one: The disability is permanent or temporary. If temporary, indicate the duration in the space provided. From ______________ to ______________
5. Does the condition cause significant impairment of age-appropriate self-care skills? ☐ Yes ☐ No
6. Does the degree of impairment to self-care skills warrant special arrangement for supervision or specialized care? ☐ Yes ☐ No

PART III

Directions: Please complete the following regarding the child's functional capabilities. Use the key below to complete the degree of assistance column for each daily living skill listed. The questions are related to the child's ability to perform age-appropriate self-care tasks as they are appropriate for the child's age. Next give an estimate of the number of hours the assistance is needed per day.

Key:
0 = Completely unable to perform alone
1 = Some assistance needed.
2 = Completely dependent.

Task	Degree of Assistance	Estimated Hours Per Day
Toileting		
Physical Mobility		
1. Positioning		
2. Walking		
3. Wheelchair		
Meeting Basic Needs		
1. Assistance with eating		
2. Assistance with playing		
3. Assistance with washing hands		
4. Dressing		
Mental		
1. Able to make age appropriate judgment about safety		
2. Appropriate interaction with peers		
3. Ability to participate in age appropriate play		
4. Maintains awareness of time, place and person		
5. Ability to communicate needs		
6. Ability to remain on a task as appropriate for age		
Reality Testing		
Other		

I certify, based on the above assessment, that the child named above has a disability and requires the assistance as indicated in performing of essential activities of daily living, self-care, and mobility.

Signature:________________________________ Date:____________________
(Licensed Physician/Psychiatrist)

License Number:____________________ License Expiration:_______________

I have read and assisted with this assessment of my child. I agree that it accurately described the level of care my child needs at this time.

Signature:________________________________ Date:____________________
(Parent)

PART IV

Directions: Please review the services listed and described in Section IV by the child care provider. Review and complete ONE of the statements below regarding the appropriateness and/or necessity of those services as they relate to the child's disability and degree of impairment.

1. ☐ Yes. All of the services listed in Section IV are necessary to provide ________________________ with adequate and appropriate care and supervision. They are also consistent with the type and degree of disability for this child.

   Signature: ____________________________________
   (Licensed Physician or Psychologist)

2. ☐ No. The services listed in Section IV are not necessary to provide ________________________ with adequate and appropriate care and supervision. They are not consistent with the type and degree of disability for this child.

   Signature: ____________________________________
   (Licensed Physician or Psychologist)

3. ☐ Some. The services listed in section IV are necessary to provide ________________________ with adequate and appropriate care and supervision. They are also consistent with the type and degree of disability for this child. The services that are appropriate are item number(s) ____________________.

   Signature: ____________________________________