	Maryland State Department of Education/Office of Child Care Child Care Scholarship Program **SPECIAL NEEDS RATE REQUEST FORM**	**Return To:** CCS Central PO Box 17015 Baltimore, MD 21297

INSTRUCTIONS:

1. The parent/caretaker completes Sections 1 and 3.
2. The parent then takes the form to the provider. The provider completes Sections 2, 3 and 4.
3. The parent/caretaker is responsible for retrieving the form from the provider and having a doctor, licensed psychologist or licensed social worker completes 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 (CCS) by the child care provider. Section 5 is confidential and may not be released once it is completed. Therefore, make a copy of the documentation prior to submission.

Section 1 PARENT/CARETAKER COMPLETES	
Name of Child with a Disability	Child's (DOB)
First Name:	Last Name:
Party ID	Parent's CCATS ID MM/DD/YYYY
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:

_____
(Doctor, psychologist, social worker'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. PROVIDER WILL HAVE TO SUBMIT PROOF OF ITEM COST AND DOCUMENTATION OF PURCHASE, IF CCDF FUNDS ARE REQUESTED. PLEASE BE ADVISED THAT THE MARYLAND CCS PROGRAM RESERVES THE RIGHT TO REQUIRE DOCUMENTATION OF ANY INFORMATION SUBMITTED.**

Section 5 - DOCTOR, LICENSED PSYCHOLOGIST OR LICENSED SOCIAL WORKER

Disability Certification

Dear Physician, Licensed/Certified Psychologist or Social Worker:

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 physician, licensed/certified psychologist or social worker 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? Circle yes or no.
6. Does the degree of impairment to self-care skills warrant special arrangement for supervision or specialized care? Circle yes or 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:_____
(Physician, Psychologist, Social Worker)

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: _____
   (Physician, Psychologist, Social Worker)

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: _____
   (Physician, Psychologist, Social Worker)

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: _____