DEPARTMENT OF HUMAN SERVICES

MINNESOTA CHILD CARE ASSISTANCE PROGRAM (CCAP)

Special Needs Rate Variance Request – Parent and Provider Request

Why did I receive this form?

You requested that the Child Care Assistance Program pay a special needs rate to your provider to care for your child who has a special need(s) due to a disability requiring specialized training, services or environmental adaptation.

Purpose

Use this form to request a special needs rate for the care of a child with disabilities that exceeds the applicable maximum rate.

Instructions for the provider and parents

1. The provider and parent should complete this form together.
2. Read, fill out all questions and sign page 6 of this form.
3. Attach current documentation of the child's special need(s) and any additional pages.

   Documentation

   - If the child has a Special Education Assessment or Educational Plan - such as an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) - the most recent assessment or plan must be submitted.

   Other documentation includes, but is not limited to:

   - Report/assessment from a mental health professional (such as psychiatrist, psychologist, counselor, social worker or other mental health specialist);
   - Medical documentation from a health care provider (such as physician, physical therapist or other medical specialist);
   - Letter(s) from county or school social worker;
   - Service referrals
   - Other professional documentation from a practitioner, who is currently or has in the past provided services related to the child's special need(s), or diagnosed the child.
4. Submit the completed form, any additional pages and documentation to your Child Care Assistance Program worker.
   - If questions are not answered, the request will be returned without a decision.
   - If sufficient documentation of the child's special need(s) is not included, the request will be denied.

Request criteria

The Child Care Assistance Program limits approval of the special needs rate to the following:

- The child has a verified disability.
- The provider requires specialized training, services or environment adaptations to meet the needs of the child.
- The provider is compliant with the Americans with Disabilities Act (ADA).
- The provider is requesting a rate that would be charged to all families in similar situations.
- If applicable, the provider spreads the costs of caring for a child with special needs across all children in care.

If the request is approved, the rate(s) may be lower than the rate requested.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ ប្រើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលខេ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ါ. ဖဲနမ့ါ်လိဉ်ဘဉ်တါ်မၤစၢၤကလီလၢတါ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,သံကွါ်ဘဉ်ပှၤဂ့ါ်ဝီအပှၤမၤစၢၤတါ်လၢနဂီါ်မ့တမ့ါ်ကိးဘဉ် 1-844-217-3549 တက့ါ.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-4194-ENG 6-19

MINNESOTA CHILD CARE ASSISTANCE PROGRAM (CCAP)

Special Needs Rate Variance Request – Parent and Provider Request

To request a special needs rate, complete and sign the form and attach documentation. Return the form and documentation to your child care case worker.

DATE OF REQUEST	CASE NUMBER	CHILD CARE WORKER		
AGENCY NAME				
AGENCY STREET ADDRESS	CITY		STATE	ZIP CODE

Child/parent information

CHILD'S NAME	DATE OF BIRTH
PARENT(S) NAME	COUNTY WHERE CHILD CARE OCCURS

Provider information

CHILD CARE PROVIDER OR FACILITY NAME			PROVIDER PHONE NUMBER
PROVIDER STREET ADDRESS	CITY	STATE	ZIP CODE
BEST TIME TO REACH PROVIDER	PROVIDER EMAIL ADDRESS		

TYPE OF PROVIDER

◯ Licensed family child care ◯ Licensed center ◯ Legal non-licensed provider ◯ Certified license exempt center

Child care rates

The provider must list their standard rate(s) and the rate(s) requested. Write "N/A" if you do not have or are not requesting a certain type of rate.

	Hourly	Daily	Weekly	Other
Standard rate(s)				
Rate(s) requested				

Length of time for which special needs rate is requested

Number of months the special needs rate is requested: (A renewal will be required if need exceeds 12 months)

MONTHS

Explain how you determined the rate(s) requested. This may include specialized training, environmental adaptations and services provided to meet the needs of the child:

Show how you calculated the rate(s) requested. For example, if you request a higher hourly rate, show how the costs explained above are calculated into an hourly amount:

1. Provider – Answer only the questions for your provider type.

Licensed centers and certified license exempt centers only: For this child's classroom:

A. What is the ratio of staff to children when this child is present?

B. Has the ratio of staff to children been increased to care for this child? ◯ Yes ◯ No

DESCRIBE

Licensed family child care and legal non-licensed family providers only:

A. What is your typical group size when this child is present?

B. Are you currently serving fewer children in order to care for this child? ◯ Yes ◯ No

If yes, how many fewer children are you serving?

C. Is or will there be a helper present when this child is present? ◯ Yes ◯ No

If yes, what qualifications or training does the helper have?

DESCRIBE

If yes, is the helper present when this child is **not** scheduled? ◯ Yes ◯ No

DESCRIBE

Special needs information

2. What special needs does this child have? Answer this question and attach documentation of the child's special need(s) as described in the instructions.

DESCRIBE

3. Describe how the care of this child in the child care setting differs from that of other children of the same age. If there are no differences in an area, write "N/A"

	Describe what this child does during the routine or task that requires additional support
Meal time	
Indoor play time	
Toileting	
Outdoor play time	
Nap time	
Communication of needs	
Interaction with peers and adults	
Other activities	

4. How have the child care environment and/or daily activities been adapted to meet the needs of this child?

DESCRIBE

5. If the provider or anyone else within the child care setting who works with this child received training, coursework or consulting services that **specifically relate to the care of this child**, list the training, coursework or consulting services below. This may include formal or informal training and consultation (Example: Services through The Center for Inclusive Child Care, Child Care Resource and Referral agencies, community organizations, meeting in person, online, etc.). Attach additional pages if needed.

List name of training/course, agency and date completed		How this relates to the care of this child
NAME OF TRAINING		
AGENCY THAT PROVIDED TRAINING		
PERSON COMPLETING THIS TRAINING	DATE COMPLETED	
NAME OF TRAINING		
AGENCY THAT PROVIDED TRAINING		
PERSON COMPLETING THIS TRAINING	DATE COMPLETED	
NAME OF TRAINING		
AGENCY THAT PROVIDED TRAINING		
PERSON COMPLETING THIS TRAINING	DATE COMPLETED	

6. What other skills, experience or resources does the provider have that helps to meet the needs of this child? If the provider has a training plan to meet the needs of this child, please describe (this may include training or coursework you plan to take in the future).

DESCRIBE

7. **Provider:** Describe any changes that would result from the Special Needs Rate.

DESCRIBE

8. What resources are being used to meet the needs **of this child**?

Education and community-based resources and services	Check if currently used
Head Start / Early Head Start*	☐
Local school district – early childhood/kindergarten screening, preschool services	☐
Local school district – school age services or special education*	☐
Help Me Grow Infant and Toddler Intervention (birth to age 3) or Preschool Special Education Services (age 3 to kindergarten entry)*	☐
Early Childhood Family Education (ECFE)	☐
County public health or social services (e.g. personal care assistance services, county case management Services)	☐
Other resources or services (please list): _____	☐

*If the child receives services from another program, and the hours overlap with the times you care for this child, please describe the child's schedule below. Example: The child attends early childhood special education on Tuesdays from 9 a.m. to noon during the school year. Otherwise the child attends child care Monday through Friday from 8 a.m. to 2 p.m.

Acknowledgement and authorization for release of information

Child care provider

I understand:

- As a child care provider I am responsible to comply with the applicable provisions of the Americans with Disabilities Act (see http://childcarelaw.org)
- That the information provided on this form may be reviewed by Minnesota Department of Human Services and/or Department of Education staff
- This authorization will end when this child's participation in the Child Care Assistance Program ends or when I no longer care for this child.

I verify that:

- The rate I am requesting is the same rate that would be charged for similar services provided to a child in a family not receiving child care assistance
- I am not receiving payment for any special accommodations to care for this child from any other funding source.

I agree to contact the agency if there are any changes in care for this child.

PROVIDER SIGNATURE	DATE

Parent

Acknowledgement

I reviewed this form. To the best of my knowledge, the information provided is true.

Giving permission

I give permission to the Minnesota Department of Human Services and its agencies to share the information and supporting documentation in this request with the Minnesota Department of Education in order to review and make a decision on the Special Needs Rate Request being made for my child. This information will be used to complete the Special Needs Rate Request process for the Child Care Assistance Program.

Consequences

State and federal privacy laws protect my records. I know:

- Why I am being asked to share/release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already shared/requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by the Minnesota Department of Human Services, it may no longer be protected by this authorization
- This authorization will end when my participation in the Child Care Assistance Program ends or when the provider is no longer caring for the child.

PARENT SIGNATURE	DATE