County Case No.: _____Return Form To: _____

CHILD WITH SPECIAL NEEDS ADDITIONAL EXPENSE DOCUMENTATION*

Name of Child:_____

Child's DCS ID No.:_____

Has the child been identified as having special needs? ρ YES ρ NO

Note: Must be completed by a representative from the local mental health/developmental disabilities/substance abuse services (MH/DD/SAS) or local education agency (LEA).

Staff of MH/DD/SAS or LEA: Review the Individual Family Service Plan (IFSP) or Individual Education Plan (IEP) with the Provider to determine the mainstreaming services and activities required of the Provider. Complete I, II, and III jointly with the Provider:

I. Provider Care Plan: List specific services or activities which require additional costs to be carried out to help ensure successful placement of the child with special needs, including intensity and frequency of that service.

II. Additional Expenditures: List additional supplies, staff time, equipment, modification of equipment needed to complete the specific services or activities. Specify if it is a one-time need or a recurring need.

III. Cost: List the monthly cost of each additional expenditure in the chart below. Please indicate if expenditure(s) is a one-time cost. Be sure to total the costs.

	I. Provider Care Plan	II. Additional Expenditures	III. Cost
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
		Requested Monthly Supplement Total:	_____

_____
Provider Signature

_____
Name of Facility

( )_____
Area Code **Telephone Number**

_____
Date Services Began or Will Begin

Note: Mail original form to local department of social service (DSS) or local purchasing agency (LPA). The provider and MH/DD/SAS or LEA must retain a copy.

_____
Agency Representative Signature

Indicate Agency: r MH/DD/SAS r LEA

_____
Position/Title

_____
Mailing Address

_____
City

_____
Zip Code

( )_____
Area Code **Telephone Number**

White Original: Local DSS or LPA **Pink Copy: Provider** **Yellow Copy: MH/DD/SAS or LEA**