County Case #:_____**Return Form To:** _____

PROVIDER INFORMATION FORM

To obtain the supplemental payment, the child has to be identified as a child with special needs by the local mental health/developmental disabilities/substance abuse services (MH/DD/SAS) or local education agency (LEA) and determined eligible by the local department of social services (DSS) or other local purchasing agency (LPA) for subsidized child care. Eligibility for the supplemental payment is contingent upon the provider's compliance with the activities designated for the provider in the child's Individual Education Plan (IEP). Also, consultation and specialized therapies or educational services are to be paid with MH/DD/SAS or LEA funds, not subsidized child care funds. Payment will be made only for approved child care services provided by an eligible provider for as long as public child care funds are available to the local purchasing agency and the child remains eligible for assistance.

To be completed by the Provider:

1. Name of Facility or Individual Provider:_____

2. Facility ID No.:_____Telephone :(   )_____

3. License or Registration number of Facility if not currently approved to participate in the subsidized child care program:_____

4. Name of child with special needs:_____Child's Age:_____

5. Number of children **with** special needs enrolled in your child care arrangement:_____

6. Number of children **without** special needs enrolled in your child care arrangement:_____
    Note: The number of children enrolled **without** special needs must be at least 60%, except for nonlicensed home arrangements.

7. I am requesting the Special Needs Supplemental Rate for the additional costs incurred for mainstreaming.

_____   _____   _____
   Provider's Name (Please Print)   **Signature of Provider**   **Date**

Provider and staff of mental health/developmental disabilities/substance abuse services or local education agency: In order to receive payment for the supplement, the provider must complete the Provider Section of Form DCD-0454B and return all three copies to the local DSS or LPA. The local DSS or LPA completes the form indicating the supplement approval and keeps the <u>white</u> original. The local DSS or LPA returns the <u>pink</u> copy to the provider and the <u>yellow</u> copy to MH/DD/SAS or the LEA.

TO BE COMPLETED BY THE LOCAL DEPARTMENT OF SOCIAL SERVICES OR LOCAL PURCHASING AGENCY:

Amount Approved for Monthly Supplemental Payment: $_____

Approved By:_____

Name of Agency:_____

Signature of Agency Representative:_____

Effective Date of Supplemental Payment:_____

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