CERTIFICATION FOR INCLUSION ASSISTANCE RATE

Local Workforce Development Board:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SECTION I: Identifying Information–to be completed by parent/guardian

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| **Child’s Name**  | **Chronological Age:** **Years** **Months**  |
| **Parents’ Names** |
| **Home Address: Street** | **City**  | **Zip**  | **County** |
| **Daytime Telephone Number** | **Evening Telephone Number** |

To be eligible for the inclusion assistance rate, the child must be receiving or participating in one of the following (check all that apply):

 \_\_\_Supplemental Security Income (SSI) benefits

 \_\_\_Social Security Disability Insurance (SSDI) benefits

 \_\_\_Early Childhood Intervention (ECI) services\*

 \_\_\_An Early Head Start or Head Start program that identifies the child as having a disability

 \_\_\_Public school special education services—including preschool programs for children with disabilities (PPCD)\*

\*Please submit an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP).

**PARENT AUTHORIZATION FOR ADDITIONAL INFORMATION OR RECORDS**

**I do hereby authorize, ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,**

 **(Name of person or organization)**

**having information or records concerning my child, to furnish such information to a representative of the Workforce Solutions Office child care contractor.**

**Name of Representative:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Address:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I also grant permission to the Board’s designated qualified professional to observe my child at the child care facility and to obtain information that may have a bearing on the education and development of my child.**

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**Parent Signature Date**

This form aids in assessing the child’s need for adult assistance in the child care facility. The information provided will establish a framework for meeting the child’s individual needs in a child care environment. Your information about assistance will help to determine if additional funding may be provided.

# SECTION II: Child’s Needs–to be completed by parent/guardian

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| **NOTE: Adult assistance is defined as additional, direct caregiver support to children who have developmental needs atypical for their chronological age. The purpose of this support is to enable children with disabilities to participate more fully in daily child care activities.** | **NEEDS ADULT****ASSISTANCE** |
| **Check whether or not the child needs adult assistance in each of the following assistance areas:** | **Yes** | **No** |
| **1. Dressing/Undressing** |  |  |
| **2. Personal Hygiene** |  |  |
| **3. Eating (adaptive eating utensils or special procedures)** |  |  |
| **4. Toileting** |  |  |
| **5. Safety (danger to self, peers, or staff)** |  |  |
| **6. Adaptive Equipment Management (needs and/or use)** |  |  |
| **7. Medical and/or Behavioral Procedures (needs and/or use)** |  |  |
| **8. Other Programming Areas of Need (specify):**  |  |  |

**If you have indicated that this child needs adult assistance in one or more of the areas listed above, please describe the assistance needed and indicate how often you feel it is needed:**

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| AREA OF ASSISTANCE(from items 1 - 8 above) | DESCRIPTION OF ASSISTANCE NEEDED | HOW OFTEN NEEDED | LEAVE BLANK FOR OFFICE ONLY |
| 1. Dressing/ Undressing |  |   |  |        |        |
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| 2. Personal Hygiene |  |   |  |        |        |
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| 3. Eating |  |  |  |        |        |
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| 4. Toileting |  |  |  |        |        |
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| AREA OF ASSISTANCE(from items 1 - 8 above) | DESCRIPTION OF ASSISTANCE NEEDED | HOW OFTEN NEEDED | LEAVE BLANKFOR OFFICE ONLY |
| 5. Safety |  |  |  |        |        |
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| 6. Adaptive Equipment   |  |  |  |        |        |
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| 7. Medical and/or Behavioral  |  |  |  |        |        |
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| 8. Other  |  |  |  |        |        |
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# SECTION III: Child Care Plan–to be completed by child care provider

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| **Facility Name** | **Child Care Licensing Provider Number** |
| **Facility Address: Street**  | **City**  | **Zip** | **County** |
| **Provider Telephone Number** | **Customer Number** |

The plan must address the child’s stated needs, including any special equipment required. State the adaptations you will make to enable this child to have access to and participate in program activities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State your plan for adjusting your staff ratios in order to meet this child’s needs:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you written part of this plan on an extra page? \_\_\_\_Yes \_\_\_\_No

I have reviewed this child’s special needs with the parent and completed a plan for meeting these needs and agree to:

* follow the plan;
* review the plan and update it at least once a year;
* maintain compliance with licensing requirements;
* have every staff person caring for this child instructed in meeting this child’s special needs;
* document that onsite consultation and resource materials have been provided by a qualified professional regarding the nature of the child’s disability and the child care plan;
* have the director and at least one of this child’s direct care staff trained in special needs within six months; and
* have training certificates available for child care contractor review.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature Date**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child Care Provider Signature Date**

Send form to the child care contractor immediately. You will be notified of the approval or disapproval of this request. Approval times may vary.

SECTION IV: Authorization–to be completed by Local Workforce Development Board’s designated professional

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| **Designated Professional’s Name**  |
| **Office Address** |

 \_\_\_Current First Aid Training not met (40 TAC §746.1315).

 \_\_\_Current CPR Training not met (40 TAC §746.1315).

 \_\_\_Child Care Plan (Section III above) incomplete or inadequate.

 \_\_\_Adult assistance is required.

 \_\_\_Adult assistance is not required.

 \_\_\_Training to meet child’s needs is required.

 \_\_\_Adaptive equipment is required.

 \_\_\_Adaptive equipment is not required.

 \_\_\_Minor renovation is required.

 \_\_\_Minor renovation is not required.

**Inclusion assistance rate is authorized.** \_\_\_Yes \_\_\_No

Percent of Rate Increase: \_\_\_\_\_\_\_\_\_ Expected Duration of Inclusion Rate (months):\_\_\_\_\_\_\_\_\_

If inclusion assistance rate is not authorized, please explain why:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Signature** |  | **Date** |