# VERIFICATION FOR A CHILD experiencing A DISABLITY OR SIGNIFICANT SPECIAL NEED

To encourage providers to accept and retain children eligible for the New Hampshire Child Care Scholarship Program who are experiencing a disability or significant special need, the Department of Health and Human Services (DHHS) will pay a supplemental rate to DHHS-enrolled child care providers who care for children with a verified diagnosed disability. The special need must rise to the level of requiring additional funding for accommodations or adaptations by the child care provider.

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| **Full Name of Child** |  | **Child’s RID #** |  |

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| **SECTION I: Child Care Provider** | | | | | | | | | | | |
| Name: | | | |  | Phone #: |  | | | |  |  |
| Business Name: | | | |  | Provider Resource ID #: | | | | |  |  |
| Address: | | |  | | Email Address: | |  | | | |  |
|  |  |  |  | |  | | | | | |  |
|  |  | I certify that the child’s disability or special need is significant enough that the child requires additional funds for accommodation or classroom adaptation in the child care setting. | | | | | | | | |  |
|  |  | I certify that I will report to DHHS if the accommodations are no longer needed. | | | | | | | | |  |
|  |  | I certify that I will submit to DHHS an annual report verifying how the supplemental payments are spent. | | | | | | | | |  |
|  | Select from the following options the planned accommodations or adaptations for this child:  Some examples are provided in parenthesis. You may have other specific accommodations for your program. | | | | | | | | | |  |
|  |  | Physical changes (e.g. ramp installation, accessible rest rooms) | | | | | | | | |  |
|  |  | Adaptive equipment (e.g. adaptive chair, accessible playground equipment) | | | | | | | | |  |
|  |  | Adaptive materials (e.g. toys, books) | | | | | | | | |  |
|  |  | Training for staff related to the condition (e.g. coaching, training, technical assistance) | | | | | | | | |  |
|  |  | Additional staffing (e.g. additional hours during lunch) | | | | | | | | |  |
|  |  | Medical support (e.g. feeding tubes, meals, toileting, oxygen) | | | | | | | | |  |
|  |  | Accessible communications (e.g. providing sign language interpreters, making materials available in braille or large print)  Other (please explain): | | | | | | | | |  |
|  |  |  | | | | | | | | |  |
|  |  | | | | | | |  |  | |  |
| **Child Care Provider’s Signature** | | | | | | | |  | **Date** | |  |

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| **SECTION II: Licensed Professional**  (the Child’s aTTENDING PHYSICIAN, PHYISICIAN’S ASSISTANT, ADVANCE PRACTICE REGISTERED NURSE, LICENSED MENTAL HEALTH PROFESSIONAL, School district special education department, or area agency director) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | Phone #: | | | | |  | | | | | |  |
| Business Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | The child’s disability or special need is: (Check ALL THAT apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | |  | | Medical |  | | Physical | | | | | | |  | Developmental |  | Educational | | | | | | |  | Emotional | |  |
|  | **If the licensed professional above is the child’s attending physician, physician’s assistant, advanced practice registered nurse, or licensed mental health professional complete the information below:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | The diagnosis of the child’s disability or special need is: | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  |
|  | Is this a permanent condition? | | | | | | |  | | Yes | | | | If no, length of expected duration is: | | | | | |  | | | | | | | | |  |
|  | | No | | | |
|  |  | I am the child’s attending physician, physician’s assistant, advance practice registered nurse, or licensed mental health professional, and am providing ongoing treatment. I certify that the child’s disability or special need is significant enough that the child requires additional support in a child care setting.  If the child is at least 13 years of age but under 18 years of age, I certify that the child’s condition limits the child’s ability to care for themselves or they could cause harm to themselves or others without supervision. | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | **Signature of Licensed Professional** | | | | | | | | | | |  | | | **Title** | | | | | | |  | | | **Date** | | | |  |
|  | **If the licensed professional above is the School Administrative Units (SAU) Special Education Director or Area Agency Director complete the information below:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | The child has a current Individual Education Plan (IEP), Individual Family Services Plan (IFSP), or 504 plan. | | | | | | | | | | | | | | | | | | | | | | | | | |  | Yes |  |
|  | No |
|  |  | I certify that: I am a SAU Special Education Director or an Area Agency Director and the child’s disability or special need is significant enough that the child requires additional support in a child care setting. | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | **Signature of the SAU Director** | | | | | | | | | |  | | **Title** | | | | | | | |  | | | **Date** | | | | |  |

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| **SECTION III: PARENT/GUARDIAN** | | | | | | | | | |
|  | Parent/Guardian Name: | |  | | Phone #: | |  | |  |
|  | Address: |  | | | | | | |  |
|  | By signing below, I authorize this verification to be released to DHHS. I understand that the information will be held in the strictest confidence and that it will be reviewed by, or shared with, authorized DHHS staff involved in the authorization of Child Care Scholarship. For permanent special needs verification is required only once. For all others verification is required annually. | | | | | | | |  |
|  | **Parent/Guardian’s Signature:** | | |  | | **Date:** | |  |  |
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# Instructions for Verification for a Child Experiencing Significant Special Need

**PURPOSE:**

The “Verification for a Child Experiencing a Disability or Significant Special Need” is used to verify that a child has a medical, physical, developmental, educational and/or emotional condition and is eligible to receive the differential rate for the New Hampshire Child Care Scholarship Program.

**INSTRUCTIONS:**

The child care provider, licensed professional and parent/guardian who can verify the child’s disability or special need must print or type the information to complete ”Verification for a Child Experiencing a Disability or Significant Special Need.” For Employment-Related Child Care, “Verification for a Child Experiencing a Disability or Significant Special Need” is provided to the family at the initial eligibility interview or upon request if the child has a disability or special need.

For Preventive and Protective Child Care, “Verification for a Child Experiencing a Disability or Significant Special Needs” is made available by the Child Protective Service Worker (CPSW) or Family Resource Center if the child is likely to have a disability or special need.

The parent/guardian must sign and date the form, authorizing the release of information to DHHS and provide it to the child’s attending Physician, Physician’s Assistant, Advance Practice Registered Nurse, or Licensed Mental Health Professional **OR** School District Special Education Department, or Area Agency Director who can verify the disability or special need and return it as below. All sections **MUST** be complete. An incomplete form shall **NOT** be accepted and no differential rate will be authorized. The differential payment shall not be authorized if the child does not require additional funds for accommodation or classroom adaptation.

**FORM COMPLETION:**

**SECTION I: Child Care Provider:**

* Enter the child’s full name.
* Enter the child’s RID number.
* Enter the child care provider’s full name, telephone number, business name (if applicable), provider resource ID number, address and email address.
* Check off the certification that the child requires additional funds for accommodation or classroom adaptation and indicate what the accommodation or adaptation is for the child.
* Check off the certification agreeing to report to DHHS if the accommodations are no longer needed.
* Check off the certification agreeing to submit to DHHS an annual report verifying how the supplemental payments are spent, which include all DHHS requested information necessary for program monitoring.
* Indicate the accommodations or adaptions for the child. If ‘Other’ please explain.
* Sign and date the form.

**SECTION II: Licensed Professional (Licensed Health Professional OR Licensed Educational/Area Agency):**

* Enter the professional’s full name, telephone number, business name (if applicable), and address.
* Indicate the child’s disability or special need.

**If the licensed professional is the child’s attending Physician, Physician’s Assistant, Advanced Practice Registered Nurse or Licensed Mental Health Professional:**

* Enter the child’s diagnosis.
* Indicate if this is a permanent condition and if not, the length of the expected duration.
* Check the box certifying the professional’s role and that the disability or special need is significant enough to require additional support in a child care setting; and if the child is 13 through 17 years of age, the child’s condition limits the child’s ability to care for themselves or they would cause harm to themselves or others without supervision.
* Sign, enter the professional’s title and date the form.
* This section must be completed by the licensed professional **NOT** the child care provider.

**If the licensed professional is the SAU Special Education Director or Area Agency Director:**

* Indicate if the child has a current IEP or 504 plan.
* Check the box certifying the professional’s role and that the disability or special need is significant enough to require additional support in a child care setting.
* Sign, enter the professional’s title and date the form.
  + The differential becomes effective the first Monday following the date DHHS receives the completed form.
* This section must be completed by the licensed professional **NOT** the child care provider.

**SECTION III: Parent/Guardian:**

* Enter the parent/guardian’s full name, telephone number, and address.
* Sign and date the form to authorize the release of information.
* Provide the form to the licensed professional for verification.

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| Either the parent or licensed professional may return the completed form to DHHS. | |
| **For Employment Related Child Care:**  DHHS Centralized Scanning Unit  PO Box 181  Concord NH 03301 | **For DCYF Preventive and Protective Child Care:**  NH Department of Health and Human Services  ATTN: DCYF Provider Relations  Brown 3rd Floor  129 Pleasant St  Concord, NH 03301 |
| **Keep a copy for your records** | |

**RETENTION:**

Form 2690 is retained in the child’s eligibility record by DHHS.