Suffolk County Department of Social Services
FCSA Child Care Bureau

APPLICATION FOR ADDITIONAL FUNDING FOR A SPECIAL NEEDS CHILD

To: Child Care Unit
3455 Veteran's Memorial Highway
Ronkonkoma, NY 11779

Date: _____

Name of Child Care Facility: _____

Re: Case Name: _____

Child's Name: _____ **Date of Birth:** _____

All sections must be completed and appropriate documentation submitted to process the application in a timely manner.

Provider Credentials

☐ licensed
☐ registered
☐ certified

Provider Address:

Address where child care is being provided: _____

_____

Vendor ID

SCDSS Vendor ID: _____

Other Program Services

To the best of your knowledge is the child receiving program services authorized by:

- **Article 89 of the Education Law:** ☐ Yes ☐ No ☐ Don't know
- **Medical Rehabilitation Program for Handicapped Children:** ☐ Yes ☐ No ☐ Don't know

Release Form

☐ Release form attached signed by the child's parent or grantee allowing information to be provided and released to the Department of Social Services.

Other Special Needs Children

Are there any other special needs children approved for additional funding by this Department at the address where this child receives care?

☐ No
☐ Yes. List names: _____

_____

P.O. BOX 18100
HAUPPAUGE, NY 11788-8900
www.suffolkcountyny.gov/departments/socialservices
Child Care Unit Fax #: (631) 854-3331

Funding Request

Indicate if the special needs funding requested is a one-time only amount for specific additional costs associated with the special needs child, and/or recurring costs, and how much is being requested.

☐ **One-time only additional costs.** Amount: $_____

☐ **Recurring costs, Amount:**

Weekly Rate: $ _____ **Daily Rate:** $_____

Part-day Rate: $ _____ **Hourly Rate**: $ _____

Provider Justification for a Special Needs Rate

Verification attached of additional costs and/or services associated with the above special needs child. Costs must be identified as recurring or one-time only. Included must be a justification for these costs. If additional staffing costs are to be incurred the only amount that may be included is the estimated time needed for the special needs child. Costs must directly relate to the provision of appropriate child care for the special needs child only.

☐ **Purchase or rental of equipment**

Justification:_____

_____

☐ **Maintenance of apparatus which assists in breathing, feeding or toileting**

Justification:_____

_____

☐ **Supervision of physical activities, such as infant stimulation and follow-up activities recommended by a therapist, physician or other specialist**

Justification:_____

_____

☐ **Minor modifications to the environment to make it appropriate for a specific child (i.e., handrails)**

Justification:_____

_____

☐ **Materials and supplies for use with a child on a routine basis as recommended by a therapist, physician or other specialist**

Justification:_____

_____

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☐ **Increased utility costs due to the use of therapeutic machines, such as respirators**

Justification:_____

_____

☐ **Transportation of children to and from prescribed therapy sessions**

Justification:_____

_____

☐ **Additional staffing when needed to allow a caregiver to work on an individualized basis with a child for scheduled time periods. Employee Name:_____ Hire Date:_____**

Justification:_____

_____

☐ **Increased time and attention needed to provide appropriate care is such that a child care provider is unable to accept additional children.**

Justification:_____

_____

☐ **Other, Explain:** _____

Justification:_____

_____

Comments or Additional Information or Explanation:

_____

_____

_____

_____

_____

_____

Person completing this Application:

Name (Print): _____

Title: _____

Phone Number: (_____) _____

Signature:

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