



## Special Needs Child Care Rate Request

Child's name (print)	Child's Date of Birth	
Parent's Name (print)	Client ID #	
Child Care Provider's Name (print)	Provider SSPS#	Telephone #
<p>Children with special needs generally have physical, emotional or mental challenges limiting one or more major life activities. Major life activities mean things like breathing, hearing, seeing, speaking, walking, using arms and hands, learning and playing. <b>List relevant medical and/or mental health diagnosis if available.</b></p>		

**Please attach documentation to support the severity of the child's condition and level of care needed in a child care setting.**

Documentation must be from:

An individual who is not employed by the child care facility, nor a relative of the child's family; and

**A** health, mental health, education, or social service professional with at least a master's degree or a registered nurse.

Examples of supporting documentation that may be accepted are:

Individual Habilitation Plan (IHP), Individual Education Plan (IEP) Individual Family Service Plan (IFSP), health records, mental health assessments.

### Needs of Child

**To Be Completed by the Provider:**

Please use this space to describe this child's specific needs and how you will support them. Please use specific examples. Include any tasks that you will perform that requires extra care above and beyond what you do for a typical child of the same age in your care.

Parent Name:	Child Name:	Client ID:
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**Child Care Rate Request**

What is the child care rate you are requesting in addition to the regular rate?

Hourly   
 Daily   
 Weekly   
 Monthly

*Please note: DCYF converts all level 2 special needs payment rates into an hourly rate subject to maximum rate limits outlined in WACs 110-15-0225, 110-15-0230, and 110-15-0235*

What type of child care provider are you?

Family, Friends, and Neighbors (FFN)   
 Licensed Family Home (LFH)   
 Licensed Center

Will someone be dedicated to providing care for this child one-on-one?     Yes     No

If yes, the name of the person providing one-on-one care:

**By signing this form, I acknowledge my request for a special needs rate:**

<b>Parent Signature</b>	<b>Date</b>
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<b>Child Care Provider Signature</b>	<b>Date</b>
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Phone: 844-626-8687      Child Care Subsidy Contact Center  
Fax: 1-877-309-9747      Department of Children, Youth, and Families  
P.O. Box 11346  
Tacoma WA 98411-9903

**The following agencies may provide resource information for you and your child:**  
Aging and Disability Services Administration, <http://www.aasa.dshs.wa.gov>, 1-800-422-3263  
The Arc of WA, Parent to Parent, <http://www.arcwa.org>, 1-888-754-8798  
Early Intervention Services, Birth to Three [www.withinreachwa.org](http://www.withinreachwa.org) 1-800-322-2588  
Child Care Aware of Washington, <http://www.childcareaware.org/> 1-800-446-1114  
Special Education Services, Public School System