

Alaska Child Care Resource and Referral Network-Alaska IN!

Dear Parent/Guardian,

Thank you for your interest in Alaska IN! - the program that supports the inclusion of children with special needs in child care. The following information is provided for you to learn more about the program and the application process.

PROGRAM INFORMATION

➤ What are the criteria to participate in this program?

If you are a parent/guardian participating in the state Child Care Assistance Program and you have a child under the age of 13 with special needs requiring additional services, you may be eligible for a special needs supplement and additional support in finding and keeping child care that best meets your child's needs.

➤ How can my child's caregiver receive the special needs supplement and additional support?

Contact a Child Care Resource and Referral (CCR&R) agency. CCR&R staff will discuss your child's needs with you and your child care provider to determine additional accommodations needed in care. They will also determine whether the accommodations needed qualify for the special needs supplement and will provide that information to you and your Child Care Assistance Program office.

➤ Can I get child care assistance before I complete the eligibility process for the supplemental rate?

Yes. If you are participating in the state Child Care Assistance Program, your provider will be paid at your determined rate until a supplemental rate is authorized. The supplemental rate may be paid for one month prior to your determination.

➤ Can I get help to find child care?

Yes. CCR&R staff can help you find child care that will meet your child's special needs. They can also assist your child care provider(s) to access training and additional resources to help them meet your child's special needs.

APPLICATION INSTRUCTIONS

1. Complete the following forms and return them to your CCR&R agency: Application for Special Needs Supplement, Authorization for Exchange of Information, and Special Needs Documentation.
2. You and your child care provider will be contacted to complete the Accommodations Scale to determine eligibility. If eligible, processing will begin to access the supplement.

If you have any questions about Alaska IN!, the application process or would like to apply, please contact the CCR&R agency nearest you (see contact information below). We look forward to working with you.

Sincerely,

Alaska IN! Case Manager



**Alaska Child Care Resource and Referral Network-Alaska IN!
APPLICATION FOR SPECIAL NEEDS SUPPLEMENT**

Family Information

Parent/Guardian Name: _____

I am requesting a Special Needs Supplement for:

Child's Name: _____ Date of Birth: _____

Relationship to Child: _____

Physical Address: _____

Mailing Address (if different): _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-Mail Address: _____

Provider Information or **Seeking Child Care Provider**

Name of Child Care Provider: _____

Provider Address: _____

Provider Phone: _____

Please read and initial the following requirements.

_____ I understand that I must be receiving State of Alaska child care assistance funds in _____ order for my child's provider to receive the Special Needs Supplement.

_____ I am participating in the following state Child Care Assistance Program:

- _____ **PASS I - Division of Public Assistance (DPA)**
DPA office community/contact: _____
- _____ **PASS II or PASS III - Local Administrator (LA)**
LA office community/contact: _____

_____ I understand that Alaska IN! is a project supported by the State of Alaska and files may be reviewed for auditing purposes only.

Parent/Guardian Signature

Date

<u>For Office Use Only</u>	<u>Date Received</u>
• Documentation of Special Need	_____
• Authorization for Exchange of Information	_____
• Accommodations Scale	_____
• Scoring Sheet for Accommodations Scale	_____
• Provider Training Plan	_____
• Special Needs Supplement Authorization	_____



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AUTHORIZATION FOR EXCHANGE OF INFORMATION

Instructions: Parent/Guardian: Please complete and return with your Alaska IN! Application for Special Needs Supplement

Child Care Resource & Referral Staff: When sharing this form with a person/agency listed below, cover the information of all other parties.

Child's Name: Date of Birth:

Address:

I, _____, authorize the mutual exchange of information
Parent/Legal Guardian
regarding _____ between thread and the persons/agencies listed below.
Child's Name Name of CCR&R Agency

[] Child Care Provider:
Family Child Care (Approved Home, Licensed Home, Group Home) or Child Care Center
Address:
Phone #:

[] Child Care Assistance Program/Contact:
ATAP (Pass I) or Child Care Assistance Program Local Administrator (Pass II or Pass III)
Address:
Phone #:

[] Health Care Professional:
Physician, Mental Health Professional, Infant Learning Specialist or local School personnel
Address:
Phone #:

[] Other:
Address:
Phone #:

This Authorization for Exchange of Information is valid for twelve (12) months from the date it is signed. Each person/agency will receive only their section to ensure confidentiality.

Signature of Parent/Guardian

Date

Relationship to Child



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SPECIAL NEEDS DOCUMENTATION



This form or other forms including an IEP, IFSP, medical diagnosis or mental health evaluation completed and signed by a health care professional may be used to document a special need. Information must be current within the past twelve (12) months.

Name of Health Care Professional: _____

Professional Title: _____

(Doctor, Nurse Practitioner, Public Health Nurse, Licensed Clinical Social Worker, Licensed Psychological Associate, Infant Learning Program Specialist)

Address: _____

Phone: _____



Name of Child: _____ Date of Birth: _____

Name of Parent/Legal Guardian: _____

1. Diagnosis:

2. Recommendations for care of child while he/she is in a child care environment:

Signature: _____ Date: _____

Health Care Professional

