STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division of Economic and Housing Stability
Bureau of Child Development and Head Start Collaboration

VERIFICATION FOR A CHILD EXPERIENCING A DISABLITY OR SIGNIFICANT SPECIAL NEEDS

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

Full Name of Child _____ **Child's RID #** _____

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(s) 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 an annual report to DHHS verifying how the supplemental payments are spent.

Select from the following options the planned accommodation(s) or adaptation(s) 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**

Please turnover to complete
Both sides of this form must be completed

SECTION II: LICENSED PROFESSIONAL
(CAN NOT BE COMPLETED BY THE CHILD CARE PROVIDER)

Name: _____ Phone #: _____

Business Name: _____

Address: _____

The child's disability or special need(s) is: (CHECK AS MANY AS 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 ☐ No If no, length of expected duration is: _____

☐ I certify that: I am the child's attending physician, physician's assistant, advance practice registered nurse, or licensed mental health professional, and am providing ongoing treatment; the child's disability or special need(s) is significant enough that the child requires 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 himself/herself or he/she would cause harm to himself/herself or others without supervision.

Signature **Title** **Date**

If the licensed professional above is the 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(s) is significant enough that the child requires additional support in a child care setting.

Signature **Title** **Date**

SECTION III: PARENT/GUARDIAN

Parent/Guardian Name: _____ Phone #: _____

Address: _____

By signing below, I authorize this verification to be released to the Department of Health and Human Services. I understand that the information will be held in the strictest confidence and that it will be reviewed by, or shared with, authorized Department of Health and Human Services' staff involved in the authorization of Child Care Scholarship. For chronic non-changing special needs verification is required only once. For all others verification is required annually.

Parent/Guardian's Signature: _____ **Date:** _____

Instructions to the "Verification for a Child Experiencing Significant Special Needs"

PURPOSE:

The "Verification for a Child Experiencing a Disability or Significant Special Needs" 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 Child Care Scholarship.

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 Form 2690. For Employment Related Child Care, Form 2690 is provided to the family at the initial eligibility interview or upon request if the child is likely to have a disability or special need.

For Preventive and Protective Child Care, Form 2690 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 will **NOT** be accepted and no differential rate will be authorized. The differential payment will 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 provider's name, telephone number, business name, if applicable, provider resource ID number and address.
- Check off the certification that the child requires additional funds for accommodation or classroom adaptation and indicate what the planned 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 an annual report to DHHS verifying how the supplemental payments are spent, which include all DHHS requested information necessary for program monitoring.
- Indicate the option(s) planned for accommodation(s) or adaption(s) 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 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 himself/herself or he/she would cause harm to himself/herself or others without supervision.
- Sign, enter the professional's title and date the form Sign, enter the professional's title and date the form.

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 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 of signature of the licensed professional.
- This section must be completed by the licensed professional **NOT** the child care provider.

SECTION III: Parent/Guardian:

- Enter parent'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.

Either the parent or licensed professional may return the completed form to DHHS.

For Employment Related Child Care:	**For DCYF Preventive and Protective Child Care:**
DHHS Centralized Scanning Unit PO Box 181 Concord NH 03301	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 eligibility record or at State Office.