CDD Special Accommodations Grant

Special Accommodations Grant funding is available for either 6 weeks for summer programs or for a six-month period. Do not combine time periods on the application.

Be sure you have:

- ☐ Completed all parts of the Application
- ☐ Included signed parent/guardian authorization for applying for Special Accommodations Grants
- ☐ Included Service Provider Letter of Support
- ☐ Signed the Application

Children's Integrated Services Parent/Guardian Authorization For Applying for Special Accommodation Grants

Name of Child:_____**DOB:** _____
(First) (Last)

Parent/Legal Guardian(s) (Please Print): _____

Child Care Program Applying for the Grant:_____**License #:** _____

Special Accommodations Grants are available from CDD for children with specialized needs to support their safe and successful inclusion in a high-quality child care setting. This inclusion is intended to contribute to the overall well-being of children with special needs and their families. Funds for Special Accommodations Grants are discretionary and limited. Decisions regarding partial or full funding of grant requests are the sole responsibility of the Child Development Division (CDD). Applications for Special Accommodations Grant Funds specific to an individual child should be submitted in collaboration with the team primarily serving the child and the child's family, with the permission and partnership of the child's parent/legal guardian(s).

The Children's Integrated Services (CIS) Team is a multidisciplinary team that provides early childhood expertise and support services for pregnant/postpartum women, children birth to 6 years, their families, and child care professionals. The team is made up of professionals that provide services in the following areas: Early Intervention, Early Childhood and Family Mental Health, Specialized Child Care, and Strong Families Vermont Home Visiting.

I give my permission for the CIS Team members and the following health and service providers (check all that apply):

- ❑ Primary Healthcare Provider: _____
- ❑ Children with Special Health Needs Worker: _____
- ❑ Child Development Clinic: _____
- ❑ Child Care Provider: _____
- ❑ Child Care Community Support Agency Staff: _____
- ❑ Public School (Lead Education Agency) Staff: _____
- ❑ Professional Consultants to Assist the Team with its Provision of Services: _____
- ❑ Nursing: _____
- ❑ Other:: _____

to communicate with and disclose to one another and the State the following information (check all that apply):

- ❑ Screening, assessment and/or evaluation records
- ❑ The CIS One Plan for my child and/or my family
- ❑ Records pertaining to support services checked above
- ❑ My child's Individualized Education Plan (IEP) or other plan for services (explain): _____

The purpose(s) of the disclosures authorized is (check all that apply):

- ❑ To be used in the determination of a Special Accommodations Grant application submitted by my child's child care provider.
- ❑ To support the child care program in making accommodations for my child's inclusion.

I also give my permission for CIS Team members to record the above information into the AHS CIS database for purposes of AHS's administration of the CIS Special Accommodations Grant program.

By signing this form, I understand:

- ➢ The reason(s) I am being asked to release information.
- ➢ I do not have to agree to the release of information. However, by not giving authorization, my child's child care program will not be able to apply for a Special Accommodations Grant on behalf of my child.
- ➢ If I choose not to sign this form any benefits for which I or my child and family are entitled will not be affected.
- ➢ While the AHS takes every precaution to protect my health information, once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- ➢ I may revoke this authorization at any time by contacting_____*(name)* at _____*(address)*, except to the extent that it has been acted upon.
- ➢ If I do not revoke or update this authorization, it will be in effect as long as I am receiving CIS services.
- ➢ I will be provided a copy of this form.

Signature of Individual or Parent/Guardian	Relationship to Client	Date
Name of Person Explaining Authorization Process	**Organization / Position**	**Date**

CDD Special Accommodations Grant Application

Date of Application:_____Parent/Guardian/Social Worker Consent Obtained: ☐Yes ☐No

Proposed Grant Begin Date:	Proposed Grant End Date:	
Name of Primary Contact For this request:		
Current STARS Rating:	Current Specialized Child Care Agreement on file with the Child Development Division? ☐ Yes ☐ No	
Name of Child Care Program:		
Child Care Program Address:		BFIS License #:
City:	**Zip code:**	**Phone #:**
Email Address:		
Has this program applied for a special accommodation grant in the past year? ☐ Yes ☐ No		
If you answered yes, have you submitted the SAG final report? ☐ Yes ☐ No		
CHILD'S INFORMATION (If the grant is for multiple children, please complete this page for each child.)		
Parent/Legal Guardian Name:		
Physical Address:		
City:	Zip code:	Phone #:
Child's Name:	**Date of Birth:**	
Does the child/family have an open or custody case with the Department of Children and Families, Family Services Division? ☐ **Yes** ☐ **No** **Name of Case worker:** **Email address:**		
Does this child currently receive a Child Care Financial Assistance Subsidy? ☐ Yes ☐ No If yes, what is the current CCFAP service need? What is the child's current schedule at your program? ☐ Part-Time or ☐ Full- Time **(Please provide the hours/ per day the child attends your program and do not include pre-k hours)** Mon____Tues___Wed___Thurs___Fri___		
When did the child start attending your program? (Please provide a date) _____ Please indicate if you are a pre-qualified Universal Pre-K (UPK) program: ☐ Yes ☐ No **(Please provide the hours per day the child attends** public pre-k program) Mon____Tues___Wed___Thurs___Fri___ Are you receiving UPK tuition for this child? ☐ Yes ☐ No Will you in the fall?		
Does the child/family have insurance: Please check one: ☐Medicaid ☐ Private Insurance ☐ Uninsured Medicaid #:		
Has this child been supported previously by SAG grant? ☐ Yes ☐ No Please indicate the dates of the most recent SAG grant award supporting this child:		

CDD SAG APPLICATION

1. Does the child have a current diagnosed medical and/or mental health condition? ☐ Yes ☐ No
   Please specify child's diagnosis _____

2. Has the child been required to leave a child care setting in the past due to challenges related to this present need? Please explain:

   _____

   _____

3. How has this child's diagnosed condition and/or behavior impacted the child's placement stability within this child care setting?

   _____

   _____

4. Is the child's current placement in jeopardy? Please describe:

   _____

   _____

5. Briefly describe how the child's plan shows a need for the proposed accommodations in order to successfully include the child in the child care setting: (Plans must be included and current)

   _____

   _____

6. What strategies does the child care program currently have in place to address the child's safety and behavioral and/or health concerns? (i.e., visual schedule, environmental changes, professional development, routines).

   _____

   _____

7. Please specify how effective these strategies worked so far in supporting the child in your program?

   _____

   _____

8. Does the child(ren) exhibit similar behaviors at home as well as in the child care setting? Please explain how the family and child care are communicating with each other of these issues.

   _____

   _____

9. Are you accessing any additional funding to support this child in this child care program from Early Childhood Special Education, Supervisory Union, CPCS funds, Parents, Early Intervention etc.? **If yes, please explain: Please list the name of the service provider, frequency of visits and provide details on collaborative sources of funding or in kind.**

Name of Program:	Name of Service Provider working with child and/or child care program	Frequency in the child care program? Frequency in child's home?	Please describe collaborative funding details
Children's Integrated Services (children birth up to age 6) Early Intervention Nursing Family Support Early Childhood and Family Mental Health Specialized Childcare (birth up to 12)			
Early Childhood Special Education (EEE) Ages **3-5**			
School Age Special Education (**5-12)**			
Children with Special Health Needs Workers			
Mental Health Services/Counseling			
Head Start			
Children's Personal Care Services (CPCS)			
DCF-FSD:			
Other:			

10. Describe the plan for ensuring all staff in the program have a shared understanding of their role in implementing the strategies funded with the grant?

_____

_____

11. Who is directly responsible for supervising and training the individual hired with these funds?

    Supervising_____

    Training_____

12. Please describe in detail how the addition of these grant funds will support this child and enhance quality for all children in the program setting?

_____

_____

13. How will you sustain the changes to your program once the funding ends?

_____

_____

CDD SAG APPLICATION – FUNDING REQUEST

Grant funding is limited to a maximum 6-weeks for summer care or six- month (26-week) period, and not more than $10,000 per SAG request. Start date for services supported by the SAG must be at least 30 days after the date the SAG application is received at CDD. Requests for multiple children attending the same program should complete one application and include the needs of the children who require additional supports.

A. **Consultation or Individual Aide Services:**

B. ☐ *(request is for 6 weeks (summer care only) or* ☐ *(6 months=26 weeks)*

1. Hourly rate for personnel: _____
2. Number of hours per week: _____
3. Fringe benefits: $_____(fringe cannot exceed State Cap of 10%)

C. Total Special Accommodations Grant Amount Requested from CDD: $ _____

The child care director or owner signing this application is attesting that the information on behalf of the child is true and the child's team has been involved with the completion of this application.

_____ _____

Signature Date

Child Development Division
NOB 1 North, 280 State Drive [toll free] 800-649-2642
Department for Children and Families
Waterbury, VT 05671-1040 [fax] 802-241-0846
http://dcf.vermont.gov/cdd

Agency of Human Services

Special Accommodation Grant

Service/Health Provider Information

You are receiving this form letter from a parent or a licensed Child Care Provider seeking to apply for the Special Accommodation Grant Funds through the Child Development Division. The information you provide will be used to verify this child care provider is caring for a child currently being supported by you or your agency. By completing this form, you are helping the child care provider meet the requirements.

Special Accommodation Grant funding provides assistance to licensed child care programs in Vermont that are caring for children with an identified special health need and need additional assistance to ensure their safety and inclusion within the child care program.

The funding is designed to assist child care providers in creating a safe and inclusive environment by supporting children with disabilities or developmental delays in learning, growing, and playing alongside their peers.

Grant funding may be used for the following purposes:

- Supporting staffing needs

Child Care Providers need to complete the following tasks before applying for the Special Accommodation Grant

- Have consent from the Parent or guardian to request this letter
- Obtain and provide a letter from a child's therapist, physician, or other health care provider outlining the need for additional support
- Work with a child's parents and the child's team to create a plan for the child/children in the program

SAG Grant:
Service Provider Letter of Support

Service Provider Name:	
Phone Number:	
Address:	
Email:	
Child Care Provider Name:	
Supported Child's Name:	
Please tell us about the services/support you provide to the above named child:	
Have you provided support, services or information to the child's child care provider? **Yes No** *If yes, please tell us about the support, services, or information you provided.*	
Please list any recommendations you have for the above name child in his/her child care setting such as additional staffing, equipment, training, etc.	

_____ _____

Service Provider Signature Date