

**THE DEPARTMENT OF EARLY EDUCATION AND CARE  
SUBSIDIZED CHILD CARE  
VERIFICATION OF DISABILITY/SPECIAL NEED OF CHILD**

The Department of Early Education and Care (EEC) is the Lead Agency in the Commonwealth responsible for administering the Child Care Development Fund (CCDF), which is a federal block grant that provides financial assistance to low-income, working families seeking high quality early education and out of school time care programs in Massachusetts. Federal and state regulations establish maximum household income thresholds and require Parents to participate in an approved service need activity, including work, education or training program.<sup>1</sup> On a limited basis, an exception to the income and service need activity requirements may be granted for a Parent whose child(ren) has a documented disability or special need.

Section 1A of Chapter 15D of the General Laws defines “child with special needs” as “a child who, because of temporary or permanent disabilities arising from intellectual, sensory, emotional, physical, or environmental factors, or other specific learning disabilities, is or would be unable to progress effectively in a regular school program.”

**A Parent seeking a child care subsidy must establish at least a part-time service need (employment, education and/or training) of 20 hours or more per week to qualify for subsidized child care. For full-time child care a Parent must confirm a valid service need of 30 or more hours per week. On a case by case basis, Parents who with less than full-time hours of service need may request that EEC approve a full-time subsidy for his/her child based on the child’s documented special need.**

The purpose of this form is twofold: (1) to verify the existence of a child’s disability/special need; and (2) to confirm the type of program that would best address and/or improve the disability/special need.

## **SECTION I: DISABILITY/SPECIAL NEEDS VERIFICATION**

(to be completed by the professional)

The Parent of the individual identified below has stated that, based on the child’s disability/special need, s/he is or would be unable to progress effectively in a regular school program because of temporary or permanent disabilities arising from intellectual, sensory, emotional, physical, or environmental factors, or other specific learning disabilities. Please fill out the information below to help us determine how we might meet the needs of this family.

### **Who may fill out this form:**

- If the disability/special need is of a physical nature, this form must be filled out by a currently licensed physician.
- If the disability/special need results from an emotional or mental health issue, this form may be filled out by a currently licensed (1) physician; (2) psychiatrist, (3) doctorate level psychologist, (4) physician’s assistant/nurse practitioner, or (5) psychiatric nurse.
- If the child is enrolled in Early Intervention, the Early Intervention Director may fill out this form.
- If the child is enrolled in a public school and is on an Individualized Education Plan (IEP), the Special Education Director may fill out this form. The Special Education Director must address **why the public school is not required to provide extended day or year round support as part of the child’s IEP.**

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<sup>1</sup> See 45 CFR 98.20 and 606 CMR 10.04.

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1. Your professional role (*check one – **only** professionals in roles listed here may complete this verification form*):

- Physician                       Psychiatrist                       Psychologist  
 Nurse Practitioner       Psychiatric Nurse       Physician's Assistant  
 Early Intervention Program Director (child **must** have a current IFSP attached)  
 Special Education Staff Director (child **must** have a current IEP or 504 plan attached)

2. Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Questions 3 through 5 must be answered if this form is completed by a physician, psychiatrist, psychologist, physician's assistant, nurse practitioner or psychiatric nurse:**

3. How long have you been treating this patient? \_\_\_\_\_

4. How frequently do you see this patient:

- daily    weekly    monthly    other (specify frequency) \_\_\_\_\_

5. Please state the approximate date that the disability/special need commenced:

\_\_\_\_\_ AND indicate the likely duration of the condition:

- Permanent    At least 1 year, but not permanent    6 months to 1 year    6 months or less

**Question 6 must be completed regardless of the type of professional completing this form:**

6. Required documentation to be attached to this verification form:

- A letter on official letterhead of the professional completing this form providing specific information about the child's disability/special need. This letter must address each of the following points:
- identification of the child's disability/special need;
  - explanation of the relationship between the disability/special need and the amount of time recommended for child care, including the number of days per week and hours per day (e.g., more than 6 hours per day or less than 6 hours per day); and
  - explanation of how the child will benefit from being enrolled in an early education and/or out of school time care program. For purposes of demonstrating the benefit to the child, EEC expects a statement regarding how the program will positively impact and/or improve the child's disability/special need. If this form is being completed by an Early Intervention Director or Special Education Director, the letter must **confirm how the IFSP, IEP or 504 Plan is insufficient and/or how child care provided by EEC will supplement** the support provided by Department of Elementary and Secondary Education or Department of Public Health.

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7. If this form has been completed by an Early Intervention Director, please attach a current IFSP to verify active participation in Early Intervention.
  
8. If this form has been completed by a Special Education Director, a current IEP and/or 504 Plan to verify involvement in a public Special Education program must be provided.

Signature of professional: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

*Please note you may be contacted by an EEC representative to verify this information. EEC reserves the right to deny or reject a claim of disability/special need if the verification form and/or its required attachments are incomplete or deemed inadequate. If you have any questions or concerns, please contact the Financial Assistance Unit at EEC (617-988-6600).*

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**SECTION II: MEDICAL RECORDS RELEASE (to be completed by the Parent)**

**I am seeking full-time early education and care** from the Department of Early Education and Care based on my child's disability/special need. I authorize the professional (*categories listed above*) identified in Section I to release the information requested on this form for the following individual: \_\_\_\_\_ . I also authorize the professional to share medical records or other information about the disability and/or special need listed in Section I with the Subsidy Administrator and/or EEC, in order to determine eligibility for financial assistance for child care. I further authorize the Subsidy Administrator and/or EEC to contact the professional identified in Section I to verify the information provided on this form and to discuss his/her diagnosis of a disability/special need **as it applies to the need for early education and care services.**

This form authorizes the professional to release most medical or health information with the following exception. The professional identified in Section I cannot disclose the following medical or health information, unless such disclosure is expressly authorized. Please check the box next to the each item below if you specifically authorize the professional to share the information described therein.

- I authorize the professional identified in Section I to share information about AIDS/HIV status.
  
- I authorize the professional identified in Section I to share information about drug or alcohol use.
  
- I authorize the professional identified in Section I to share information about psychological/psychiatric disorders.

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I understand that this medical records release is valid for one year from the date signed below, unless I have cancelled the release in writing prior to its expiration.

I understand that I may cancel this medical records release at any time by sending a letter to the professional identified in Section I.

I also understand that, even if I cancel this release, the professional cannot take back any information that s/he has shared with the Subsidy Administrator and/or EEC when s/he had the authorization to do so.

Furthermore, I understand that my decision to authorize the professional identified in Section I to share medical information with the Subsidy Administrator and/or EEC is voluntary. However, I understand that if I do not authorize the professional to share medical information with the Subsidy Administrator and/or EEC, a determination regarding my child's disability and/or special need cannot be made and my child's eligibility for child care financial assistance will be decided without consideration of the disability or special need claimed. I understand that EEC may deny or reject this claim of disability/special need if the verification form and/or its required attachments are incomplete or deemed inadequate.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print**

Parent's name: \_\_\_\_\_ Child's name & age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Second Parent: \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ Phone: \_\_\_\_\_

**THIS FORM MUST BE COMPLETED IN FULL AND RETURNED TO YOUR SUBSIDY ADMINISTRATOR. IT IS ALSO ADVISED THAT THE MEDICAL PROFESSIONAL AND THE PARENT KEEP A COPY OF THIS FORM FOR HIS/HER OWN FILES.**

**ANY ADDITONAL CHILDREN IN THE HOUSEHOLD, NOT IDENTIFIED AS A CHILD WITH SPECIAL NEEDS, WILL HAVE HIS/HER SERVICE NEED BASED SOLELY ON THE PARENTS ELIGIBILITY FOR FULL OR PART-TIME SERVICE NEED.**