**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Early Care and Education

**Wisconsin Shares Inclusion Rate Request**

***NOTE:*** *Under Sec. 51.30, Stats. Disability information and records are confidential. In general, they can only be released to others with the informed written consent of the individual, if competent, or the guardian. The rule covers both verbal information and treatment records.*

Parents use this form to request a higher Wisconsin Shares subsidy amount. If a higher amount is approved, the increased amount is valid for one year. A new form will need to be completed every 12 months to evaluate the needs of the child and determine the cost incurred by the child care program. Personal information you provide may be used for secondary purposes   
[Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

A new form will need to be completed if there is a change in child care providers in order to determine the projected costs for the new child care program.

*Wisconsin Shares defines “disability” as: The emotional, behavioral, physical, or personal need that makes an individual physically or mentally incapable of caring for oneself, or, for a child, requiring more than the usual amount of care and supervision for the child’s age, as documented by a physician, psychologist, special educator, or other qualified licensed professional. A “disability” includes a developmental disability (Wisconsin Shares Handbook).*

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| 1. **General Information** | | | | |
| Case Number | Name - Child’s (Last and First) | | | Date of Birth – Child’s |
| Name - Parent /Guardian | | Telephone Number - Parent/Guardian | | |
| Provider Number | | Provider Address– (Street, City, State, Zip Code) | | |
| Today’s Date | | Contact – Local Agency | | |
| 1. **Disability Criteria (Parent Completes this Section)** | | | | |
| Briefly describe the disability of the child. | | | | |
| Does your child have: (Please check all that apply)?  A diagnosis by a physician or medical provider?  Verification: Please provide documentation from physician  An Individualized Family Service Plan (IFSP) from Birth-to-Three  Verification: Please provide a copy of your child’s IFSP  An Individualized Education Program (IEP) from a school district  Verification: Please provide a copy of your child’s IEP  A 504 plan *(child has an alternative plan in place to provide some assistance to participate fully in school)*  Verification: Please provide a copy of your child’s 504 plan  Other (please describe):  Verification: Please provide the necessary documentation  (If checked, please have a physician, special educator, or other licensed professional provide supporting documentation describing any adaptations and/or modifications that are recommended) | | | | |
| **SIGNATURE** - Parent/Guardian | | |  | |

**NOTE: Parents/Guardians:** *It is your responsibility to submit this form to request a higher amount to cover the cost of care for your child. After completing this request form, please submit the form to the Wisconsin Shares Child Care Coordinator or Wisconsin Shares Child Care authorization worker at the local agency.*

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| 1. **Provider Rationale (Child Care Provider completes this section)** |
| Please provide a rationale for the increased amount request. What additional costs will be incurred that are not accounted for in the regular Wisconsin Shares subsidy amount? (i.e. explanation of or list of additional expenses)  Hourly Amount Requested:  Rationale: |
| Would you and your staff benefit from additional training or technical assistance to provide care for this child?  Training  Technical assistance  Other (please describe):  None |
| If you checked one or more of the first three (3) boxes above, please discuss possible options for training and technical assistance with your local Child Care Resource and Referral Agency (CCR&R) by calling (888) 713-5437; or contact your YoungStar Technical Consultant.  **Parents:** Please discuss possible training ortechnical assistance opportunities for your child care provider with your Birth-to-3 specialist, special education service provider, and/or physician. |
| I verify that the information I’ve provided in Section 3 is accurate to the best of my knowledge.  **SIGNATURE** – Child Care Provider |
| **NOTE:** Children with disabilities do not automatically qualify for a higher subsidy amount. Instead, increased amounts are determined by local agency workers on a case-by-case basis and are informed by substantiation provided by the parent and the child care provider. If a higher amount is approved, it is the provider’s responsibility to comply with all ADA requirements. For more information on how ADA applies to child care providers, please visit https://www.ada.gov/childqanda.htm.   |  |  | | --- | --- | | 1. **Agency Use** (If amount is not greater than the local agency maximum rate or provider price, do not use. If care is provided by a licensed provider, the weekly county/tribal maximum rate may be exceeded.) | | | Date Request Approved:  Request Not Approved  Reason for denial (Required if request not approved): | Override Price End Date (12 months from Date Request Approved) | | Local Agency Comments | | | Local Agency Contact | Telephone Number – Local Agency Contact | |