

# MASSACHUSETTS DEPARTMENT OF EARLY EDUCATION AND CARE

## *Verification of Disability/Special Need for 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.<sup>1</sup> **Child care financial assistance funded by CCDF is not an entitlement.**<sup>2</sup> 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>3</sup> On a limited basis, an exception to the income and service need activity requirements may be granted for children/families receiving or in need of receiving protective services.<sup>4</sup> **CCDF funded child care cannot be authorized for purposes of providing respite care** (e.g. to give a parent time off from parenting).<sup>5</sup>

On a case by case basis, a child may access early education and out of school time care services, if the child is determined to be receiving or at risk of receiving protective services, including children determined to be special needs. 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.” **Please note:** A parent seeking a child care subsidy on behalf of his/her child must establish at least a part-time service 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/guardian 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) 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.

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<sup>1</sup> See G.L. c. 15D, § 2.

<sup>2</sup> See 42 U.S.C. 9858(d)(a).

<sup>3</sup> See 45 CFR 98.20 and 606 CMR 10.04.

<sup>4</sup> Id.

<sup>5</sup> See 45 CFR 98.20 and Federal Register/Vol. 63, No. 142 @ p. 39948-39949.

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

- Physician                       Psychiatrist                       Psychologist  
 Nurse Practitioner       Psychiatric Nurse  
 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, nurse practitioner or psychiatric nurse:**

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

4. I currently 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 include the following:
- identification of the child's 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 does not provide adequate support 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.

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

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

**Please print**

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

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

License number: \_\_\_\_\_

*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 EEC at 617-988-6600.*

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## **SECTION II: MEDICAL RECORDS RELEASE (to be completed by the parent/guardian)**

**I am seeking financial assistance** 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 Child Care Resource and Referral Agency (CCR&R), child care provider, and/or EEC, in order to determine eligibility for financial assistance for child care. I further authorize the CCR&R, child care provider 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.

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 CCR&R, child care provider, 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 CCR&R, child care provider, and/or EEC is voluntary. However, I understand that if I do not authorize the professional to share medical information with the CCR&R, child care provider, 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/Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print**

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

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

Second Parent/Guardian \_\_\_\_\_

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

**THIS FORM MUST BE RETURNED TO YOUR CHILD CARE RESOURCE AND REFERRAL AGENCY OR YOUR CONTRACTED PROVIDER/SYSTEM. IT IS ALSO ADVISED THAT THE MEDICAL PROFESSIONAL AND THE PARENT/GUARDIAN KEEP A COPY OF THIS FORM FOR HIS/HER OWN FILES.**