

**THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EXCESSIVE ABSENCE MEDICAL WAIVER FOR EEC FINANCIAL ASSISTANCE**

Dear Parent:

All children who receive child care subsidies from the Department of Early Education and Care (EEC) are expected to attend the early education and care program as scheduled in your child care authorization. Child care providers are required to make every effort to ensure that each child care slot is filled or each voucher is used at all times.

EEC's Attendance Policy states that Excessive Absences occur when a child has had more than 45 non-attended days, including any Unexplained Absences (no show, no call), within a 12 month Authorization period, or more than 15 non-attended days during an initial 12 week Provisional Authorization period. Explained Absences include events such as absences due to child illness, death in the family, emergency circumstances, religious holidays, and vacation days. If your child reaches the Excessive Absence limit of 45 non-attended days, you are responsible for payment of all additional non-attended days at the daily rate paid by the Commonwealth for the remainder of your authorization..

EEC recognizes that some children may miss more than the allotted days due to short-term or long-term medical conditions. The following Excessive Absence Medical Waiver will allow an exemption from the Excessive Absence limit for children who meet the criteria below. In order to be considered for the Excessive Absence Medical Waiver, you must submit clear documentation that your request meets the requirements below:

The following documents are required for a complete submission:

- An Excessive Absence Medical Waiver Form completed in full. Separate forms must be submitted for each child.
- A letter from the attending medical professional, on letterhead, which must address the following:
 - Identification of the child's illness;
 - Expected duration of the child's illness;
 - Explanation of how the child's medical condition *may* impact their attendance and/or participation in their early education and care program

Section I – Applicant Information (to be completed by Parent):

Date: _____

Parent Name: _____

Child's Full Names and Dates of Birth: _____

Parent Full Address: _____

Telephone Number: _____ Email: _____

Describe the reason your child should be exempted from the excessive absence policy: _____

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MEDICAL RECORDS RELEASE (to be completed by the Parent)

I am requesting a waiver from EEC's Excessive Absence policy for my child based on my child's medical needs. I authorize the professional identified in Section II to release the information requested on this form and I also authorize the professional to share medical records or other information about my child's medical condition listed in Section II with the Subsidy Administrator and/or EEC in order to determine eligibility for an excessive absence waiver. I further authorize the Subsidy Administrator and/or EEC to contact the professional identified in Section II to verify the information provided on this form and to discuss his/her diagnosis of my child's medical condition **as it applies to the child's attendance at, and participation in, early education and care services.**

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

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

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

Furthermore, I understand that my decision to authorize the professional identified in Section II 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 medical condition cannot be made and my child's eligibility for an excessive absence waiver will be denied. I understand that the Subsidy Administrator and/or EEC may deny or reject my request for an Excessive Absence Waiver if the waiver form and/or its required attachments are incomplete or deemed inadequate.

I understand that any approved waiver, including supporting documentation, will become part of my subsidy file and may be transferred to other EEC authorized Subsidy Administrators in the event that I change providers or that another Subsidy Administrator takes responsibility for my subsidy's reauthorization.

Parent Signature: _____

Date: _____

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Section II – Child Medical Information (to be completed by medical professional):

The individual identified above has stated that his/her child may have Excessive Absences from the child's early education and care program due to a medical condition. The individual has requested that EEC provide a waiver to the Excessive Absence policy because of the child's condition. Please fill out the information below to help us determine if this child is eligible for an Excessive Absence waiver. The following guidelines apply to the medical professional completing this section:

- If the child's medical need results from a physical health issue, Section II must be filled out by a licensed physician, physician assistant, or nurse practitioner.
- If the child's medical need results from an emotional or mental health issue, Section II may be filled out by a currently licensed (1) psychiatrist, (2) doctorate level psychologist, (3) nurse practitioner, or (4) psychiatric nurse.

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

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Psychiatric Nurse | <input type="checkbox"/> Psychiatrist |

2. Name of child, including date of birth: _____

3. Please state the approximate date that the child's medical 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

4. Please attach a letter on official letterhead of the health professional completing this form providing the following information:

- Identification of the child's illness;
- Expected duration of the child's illness;
- Explanation of how the child's medical condition may impact their attendance and/or participation in their early education and care program

Signature of professional: _____ Date: _____

Please print

Name: _____ Title: _____

Address: _____ Phone: _____

License number: _____

Please note you may be contacted by EEC or the Subsidy Administrator listed below to verify this information. EEC or the Subsidy Administrator reserves the right to deny or reject a waiver request if the verification form and/or its required attachments are incomplete or deemed inadequate. If you have any questions or concerns, please contact the Subsidy Administrator listed below or contact EEC at 617-988-6600.

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Please complete this form and attach all required supporting information and return to the Subsidy Administrator Listed Below:

Subsidy Administrator Agency Name: _____

Subsidy Administrator Contact Person: _____

Subsidy Administrator Phone Number: _____

Subsidy Administrator E-mail: _____

Subsidy Administrator Address: _____

APPROVAL BY SUBSIDY ADMINISTRATOR

Waiver must have both approval signatures prior to entry into CCFA

Primary Approval:

Primary Approver Name: _____

Primary Approver Job Title: _____

Primary Approver Signature: _____

Signature

Date

Supervisory Approval:

Supervisor Name: _____

Supervisor Job Title: _____

Supervisor Signature: _____

Signature

Date

Date Waiver Entered into CCFA: _____