



Boulder County has adopted a sliding payment rate schedule for children that have been determined to have additional care needs and are receiving childcare assistance benefits. Additional care needs rates may also be paid for a child who is age 13 up to age 19 and is unable to care for him/herself.

A special needs child is defined as:

- A child who has a physical or mental condition which is verified by a physician or other appropriate professional. A higher special needs rate for each child will be negotiated and connected to a specific reason for higher rates. For example, a child may need constant attention, due to a social/emotional, sensory, physical or mental condition.

If you or your provider feels that your child has a special need, the following information is required:

1. A physician or other appropriate professional must evaluate your child. Upon evaluation, please ask the physician or other appropriate professional to complete the Health Care Provider form that is in this packet regarding the type and severity of child's special needs and the additional care that is necessary to accommodate the child.
2. Please complete the enclosed Special Needs Assessment Form.
3. Please have your child care provider complete the Individual Care Plan.
4. If your child has a Neuropsychological Evaluation, IFSP, Behavior Plan, IEP or 504 Plan, please include the most recent copies with the packet.
5. Sign the attached Medical Release Form.

The Boulder County CCAP Manager or the Additional Care Needs Rate Advisory Board, will review all requests for the additional needs rate, once all of the required paperwork has been completed and returned to our office. This information will not be released to anyone without your specific written consent; it is only used to establish the appropriate payment rate for your provider. This is not a guarantee that special needs rates will be approved and paid to your child care provider. It is not mandatory for a county to pay higher rates for special needs children.

If you have any questions regarding this form, please contact the CCAP Manager at 303.441.1000 or ccap@bouldercounty.org attention: CCAP Manager in subject line.

Please return form via drop off or mail to Boulder County CCAP: 515 Coffman St., Longmont CO 80501 or email to ccap@bouldercounty.org (use Special Needs App in subject line).



BOULDER CCAP ADDITIONAL CARE NEEDS INDIVIDUAL CARE PLAN
To be completed by Child Care Provider

Child Name: _____ Child's Date of Birth ____/____/____

Parent/ Caretaker Name: _____

Child Care Provider Name: _____

Address: _____

Phone: _____ Provider CCAP ID# _____

In order for the special needs request to be reviewed for above client this form must be completed in its entirety and returned to Boulder County CCAP.

Please provide the following information about any special services or needs that the child requires while in your care. When answering these questions keep in mind, special needs rates may be paid in the event that the child you are caring for requires more care than you would normally provide for other children. It is required that a physician or another appropriate professional verify the medical or physical condition of the child.

What days and times does the child attend your center?

How long has the child been attending your center?

Explain your understanding of why this child requires extra care.

What strategies have you used to date to meet the needs of the child?

Have you hired any additional staff in order to meet the child's needs or do you provide additional staffing during care times for this child? YES NO

If yes, in what capacity:

Have you received any special training from a doctor or the parent/caretaker in order to provide medical treatment/care for the child? YES NO

How often do you provide special medical support?

DAILY More than once daily once a week once a month varies

If special medical care varies explain how often treatment is given and what type of treatment is needed:



PROVIDER ASSESSMENT pg. 2

To be completed by Child Care Provider

Describe any changes in your normal routine that you have made to accommodate this child's needs. (Example: a separate mealtime, a Behavior Plan implemented or other early intervention services).

Provider/Center Accommodations:

Describe any extra monitoring that you do for this child.

Describe any physical modifications to your home/center that you made to accommodate this child with special needs.

What personal care skills does this child need help with that are unusual for a child of this age (examples: toileting, eating, social/emotional or communication).

How much time is spent each day on providing these services:

Please comment on any different skills or activities that you use to meet this child's needs.

Referrals

Has the child been referred for development screening, evaluation or early intervention through Imagine! or your local Child Find office? If so, what was the result?

Does the child have an IFSP, IHP, behavioral plan, IEP or 504 Plan?

Accommodations that your center/home has made that aligns with the accommodations & goals of the Behavior Plan, IEP/504 Plan:

Behavioral/Social Emotional Supports

Describe any play or interpersonal behaviors that present a concern and how do you as a center/provider address them?

I understand that all special needs requests are reviewed by Boulder County CCAP. Special needs rates are not guaranteed and vary based upon the type and severity of the child's needs.



PROVIDER ASSESSMENT pg. 4

To be completed by Child Care Provider

Name of Child: _____ Parent/Caretaker Name: _____

Child's Date of Birth: ____/____/____

Please list any specific Medical Diagnosis that child has:

Please list any on-going administered medications:

Is child seen by a mental health or other therapist: Y or N

Additional information:

I understand that all special needs requests are reviewed by Boulder County CCAP. Special needs rates are not guaranteed and vary based upon the type and severity of the child's needs.

Provider Signature/ Date

Parent/Caretaker Signature / Date



Date:

Dear Health Care Provider,

The CCAP participant listed below has indicated that he/she has additional care needs child that requires a higher level of child care due to a medical, physical or emotional condition. In order to appropriately determine the level of care that is needed, we need some information from you. We want to thank you in advance for promptly completing and returning this form to us.

Parent/ Adult Caretaker Printed Name: _____

Child Name: _____ Child Date of Birth_____/_____/_____

Parent/Adult Caretaker Signature: _____

To be filled out by the Health Care Provider:

Please indicate the functionality level of the child by checking the appropriate box that best describes the child and explain the level of care that is necessary to accommodate him/her.

Mild- Special Needs:

Child exhibits repeated disruption to other children due to emotional/ behavioral/ developmental difficulties or has medical needs which requires close supervision.

Explain:

Moderate- Special Needs:

Child has a mental health diagnosis, behavioral difficulties and/or developmental delays that require intermittent one on one assistance and /or supervision, moderate medical problems such as tendency to choke. List diagnosis:

Explain:

Severe- Special Needs:

Child has mental health diagnosis, behavioral difficulties that require redirecting behavior, behavior modification, developmental delays or serious medical condition requiring specialized training. Child requires one on one assistance or supervision to keep

the child safe and to provide safety to others. Child has severe medical needs such as a feeding tube. Child displays sexual or physical aggression and /or has a history of fire setting.



HEALTHCARE PROVIDER ASSESSMENT pg.2

To be filled out by the Health Care Provider:

List diagnosis:

Explain:

Is attributable to developmental delays or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in either impairment of general intellectual functioning or adaptive behavior similar to that of a person with developmental delays.

If yes, condition:

Does the child have an Intellectual or Developmental Disability? Please list:

Has an IQ assessment been completed (if so, type of testing & date):

IQ Score:

Describe the medical facts which support your certification; including a brief statement as to how the medical facts meet the criteria of one of the categories selected above:

State the approximate date the condition commenced and the probable duration of the condition.

If another provider of health services will provide any of these treatments (for example, physical therapist, occupational therapist, etc.), please state the nature of the treatments.

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (for example, prescription drugs, physical therapy requiring special equipment, etc.):

If you have any questions regarding this form, please contact the CCAP Manager at 303.678.6014 or ccap@bouldercounty.org attention: CCAP Manager in subject line. Thank you again for completing this form.

Signature of Health Provider _____ Date ____ _
Printed Name: ____ Title: _
Address: ____
Phone: ____ Type of Practice: ____

Please return form to Parent/caretaker or mail to Boulder County CCAP: 515 Coffman St., Longmont, CO 80501 or email to ccap@bouldercounty.org (use Additional Care Needs App in subject line).