

**CHILD WITH SPECIAL NEEDS ADDITIONAL EXPENSE DOCUMENTATION\***

Name of Child: \_\_\_\_\_

Child's DCS ID No.: \_\_\_\_\_

Has the child been identified as having special needs?  YES  NO

**Note:** Must be completed by a representative from the **Regional Child Development Services Agency (CDSA)** or local education agency (LEA).

**Staff of the CDSA: Review the Individual Family Service Plan (IFSP) or Individual Education Plan (IEP) with the Provider to determine the mainstreaming services and activities required of the Provider. Complete Sections I, II, and III jointly with the Provider:**

- I.** List specific services or activities needed to help ensure successful placement of the child with special needs, including intensity and frequency of that service.
- II.** List additional supplies, staff time, equipment and modification of equipment needed to complete the specific services or activities. Specify if it is a one-time need or a recurring need.
- III.** List the monthly expense the items listed under Section II in the chart below. Please indicate if expenditure(s) is a one-time cost. Be sure to total the costs.

I. Services/Activities	II. Staff, equipment, etc.	III. Monthly Expense
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
<b>Requested Monthly Supplement Total:</b>		_____

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Name of Facility

Indicate Agency:  CDSA  LEA

( ) \_\_\_\_\_  
Area Code Telephone Number

\_\_\_\_\_  
Position/Title

\_\_\_\_\_  
Date Services Began or Will Begin

\_\_\_\_\_  
Mailing Address

**Note: Mail original form to local department of social services (DSS) or local purchasing agency (LPA). The provider and CDSA or LEA must retain a copy.**

City State Zip Code

( ) \_\_\_\_\_  
Area Code Telephone Number

**White Original: Local DSS or LPA**

**Pink Copy: Provider**

**Yellow Copy: CDSA or LEA**