County Case #:_____Return Form To: _____

PROVIDER INFORMATION FORM

To obtain the supplemental payment, the child has to be identified as a child with special needs by the regional Child Development Services Agency (CDSA) or local education agency (LEA). The child will need to be determined eligible for subsidized child care by the local department of social services (DSS) or other local purchasing agency (LPA). Eligibility for the supplemental payment is contingent upon the provider's compliance with the activities designated for the provider in the child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP). Also, consultation and specialized therapies or educational services are to be paid with other applicable funds, not subsidized child care funds. Payment will be made only for approved child care services provided by an eligible provider for as long as public child care funds are available to the local purchasing agency and the child remains eligible for assistance.

To be completed by the Provider:

1. Name of Facility or Individual Provider: _____
2. Facility ID No.: _____Telephone: ( ) _____
3. License or G.S. 110-106 number of facility if not currently approved to participate in the subsidized child care program (or indicate if nonlicensed home provider): _____
4. Name of child with special needs: _____Date of Birth: _____
5. I am requesting the Special Needs Supplemental Rate for the additional costs incurred for serving the above named child.

_____	_____	_____
Provider's Name (Please Print)	**Signature of Provider**	**Date**

Provider and staff of the regional Child Development Services Agency or local education agency: In order to receive payment for the supplement, the provider must complete the Provider Section of Form DCD-0454B and return all three copies to the local DSS or LPA. The local DSS or LPA completes the section below indicating the supplement approval and keeps the white original. The local DSS or LPA returns the pink copy to the provider and the yellow copy to CDSA or the LEA. A completed copy of the form, Child with Special Needs Additional Expense Documentation (DCD-0454A), must be attached to this form for approval.

TO BE COMPLETED BY THE LOCAL DEPARTMENT OF SOCIAL SERVICES OR LOCAL PURCHASING AGENCY:

Amount Approved for Monthly Supplemental Payment: $_____

Approved By: _____

Name of County or LPA: _____

Signature of Agency Representative: _____

Effective Date of Supplemental Payment: _____

White Original: Local DSS or LPA **Pink Copy: Provider** **Yellow Copy: CDSA or LEA**