**Wisconsin Shares Inclusion Rate Request**

Under Sec. 51.30, Stats. Disability information and records are confidential. In general, they can only be released to others with the informed written consent of the individual, if competent, or the guardian. The rule covers both verbal information and treatment records.

**Note to Parents:** Before submission of this form, please discuss possible no-cost training ortechnical assistance opportunities that may be available to your child care provider through resources such as your Birth to 3 specialist, special education service provider, and/or physician.

**Use of form:** Parents use this form to request a higher Wisconsin Shares subsidy amount. If a higher amount is approved, the increased amount is valid until the annual renewal following the 12th month. A new form will need to be completed at each renewal to evaluate the ongoing and changing needs of the child and determine any adjustments to the costs incurred by the child care program. Also, a new form will need to be completed if parents change child care providers to document and verify the costs for the new child care program. Personal information you provide may be used for secondary purposes. [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

*Wisconsin Shares defines “disability” as: The emotional, behavioral, physical, or personal need that makes an individual physically or mentally incapable of caring for oneself, or, for a child, requiring more than the usual amount of care and supervision for the child’s age, as documented by a physician, psychologist, special educator, or other qualified licensed professional. A “disability” includes a developmental disability (Wisconsin Shares Handbook).*

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| 1. **General Information** | | | | | |
| Case Number | Child’s Name (Last and First) | | | | Child’s Date of Birth |
| Parent / Guardian Name | | | Parent / Guardian Telephone Number | | |
| Provider Name | | | | | Provider Number |
| Provider Address– (Street, City, State, Zip Code) | | | | | Today’s Date |
| 1. **Disability Criteria (Parent Completes this Section)** | | | | | |
| Briefly describe the disability of the child. | | | | | |
| Does your child have: (Please check all that apply) | | | | | |
| a.  A diagnosis by a physician or medical provider?  Verification: Please provide documentation from physician | | | | | |
| b.  An Individualized Family Service Plan (IFSP) from Birth to 3 Program  Verification: Please provide a copy of your child’s IFSP | | | | | |
| c.  An Individualized Education Program (IEP) from a school district  Verification: Please provide a copy of your child’s IEP | | | | | |
| d.  A 504 plan *(a plan developed to ensure accommodations are provided to allow the child to participate fully in school)*  Verification: Please provide a copy of your child’s 504 plan | | | | | |
| e.  Other (please describe): | | | | | |
| Verification: Please provide the necessary documentation | | | | | |
| For all checked boxes, please have a physician, special educator, or other licensed professional provide supporting documentation describing any adaptations and/or modifications that are required in a child care setting. | | | | | |
| **I certify that the information I’ve provided about my child’s disability is accurate to the best of my knowledge.** | | | | | |
|  | | | |  |  |
| **SIGNATURE** - Parent/Guardian | | | |  | **DATE** |
| **Note: Parents/Guardians:** It is your responsibility to submit this form. After completing this form, please submit the form to the Wisconsin Shares Child Care Coordinator or Wisconsin Shares Child Care authorization worker at your local agency. | | | | | |
| 1. **Provider Rationale (Child Care Provider completes this section)** | | | | | |
| Children with disabilities do not automatically qualify for a higher subsidy amount. Instead, increased amounts are determined by local agency workers on a case-by-case basis according to information provided by the parent and the child care provider. The rationale provided below must include an explanation of any specialized training, services, or environment adaptations that are required to meet the needs of the child or are beyond reasonable accommodations. If the rationale is not descriptive the higher amount may be denied.  If a higher amount is approved, it is the provider’s responsibility to comply with all ADA requirements. For more information on how ADA applies to child care providers, please visit <https://www.ada.gov/childqanda.htm>.  **Limitations to the Inclusion rate:** Higher rate requests are limited to the child care provider needs. The higher rate must not be used to cover healthcare services such as: occupational therapy, physical therapy, or nursing care. | | | | | |
| Please provide a rationale for the increased subsidy amount requested. What additional costs will be incurred that are not accounted for in the regular Wisconsin Shares subsidy amount?  Hourly Amount Requested:  Rationale: | | | | | |
| **Providers:** If you or your staff would benefit from additional training or technical assistance to provide care for this child, please discuss possible options for training and technical assistance with your YoungStar Technical Consultant. You can also visit the <https://dcf.wisconsin.gov/youngstar/eci> for resources on caring for children with disabilities. | | | | | |
| **I certify that the information I’ve provided in Section 3 is accurate to the best of my knowledge.** | | | | | |
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| **SIGNATURE** – Child Care Provider | | | |  | **DATE** |
|  | | | | | |
| 1. **Agency Use Only** | | | | | |
| Request Approved   * Date Request Approved:       The inclusion rate effective date is the date that this form is approved and signed by the local agency representative. | | Request Not Approved   * Reason for denial (Required if request not approved): | | | |
| Local Agency Comments | | | | | |
| **Signature** - Local Agency Contact | | | | | Telephone Number |