Child Care Financial Assistance
Special Health Needs (Child)

A child with a special health needs is defined by the American Academy of Pediatrics (October 1998) as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that which is generally required by children.

Please Note:

- All information on this form will remain confidential.
- Incomplete forms will be denied.
- The Child Development Division (CDD) reserves the right to limit the days and hours approved for Child Care Financial Assistance.

I,_____(parent/guardian full name printed), have applied for Child Care Financial Assistance for_____(child's full name).

By signing below, I permit this form to be shared with the regional CIS Specialized Child Care Coordinator to determine my eligibility for child care financial assistance.

Parent/Guardian Signature_____ **Date**_____

A child's special health need status must be determined and documented below by **ONE** of the following:

1. Special Health Need (Child) form completed by a licensed physician, physician's assistant, nurse practitioner or advanced registered nurse practitioner (NP or ARNP), Certified Pediatric Nurse Practitioner- Primary Care (CPNP-PC), Licensed Independent Clinical Social Worker (LICSW), Licensed Clinical Mental Health Counselors (LCMHCs), or a licensed psychologist and a Children's Integrated Services (CIS) One Plan which identifies the supports the child needs to be successful within the early childhood or school-aged out-of-school-time care setting; **OR**
2. A Special Education or Early Intervention Assessment signed by a qualified professional identifies child care as part of the child's CIS One Plan, Individual Education Plan (IEP), 504 Plan, Mental Health Treatment Plan, Coordinated Services Plan (CSP), or Integrated Family Services Plan (IFSP). The Plan must identify supports the child needs to be successful within the early childhood or school-aged out-of-school care setting.

Diagnosis_____

**Attach a copy of the child's diagnosis and treatment plan that identifies the child care needs and supports.

Expected duration of condition _____

Specify the days and number of hours per week that child care is needed:

Sun ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____ Total Hours _____

Form completed by (check):

- ☐ Licensed Physician
- ☐ Physician's Assistant
- ☐ Nurse Practitioner or Advanced Registered Nurse Practitioner (NP or ARNP)
- ☐ Certified Pediatric Nurse Practitioner - Primary Care (CPNP-PC)
- ☐ Licensed Independent Clinical Social Worker (LICSW)
- ☐ Licensed Clinical Mental Health Counselors (LCMHC)
- ☐ Licensed Psychologist

Name (please print)_____ **Title**_____

Phone_____ **Address**_____

Signature_____ **Date**_____

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION