



[www.elc-marion.org](http://www.elc-marion.org)

2300 SW 17<sup>th</sup> Road  
Ocala, FL 34471

Phone (352) 369-2315

Fax (352) 369-2475

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## REQUEST FOR INCREASED REIMBURSEMENT RATE FOR CHILDREN WITH SPECIAL NEEDS

This form is to supplement **Rule 6M-4.500(7)(b)** which states: "To receive a special needs rate, in addition to the base rate, it must be requested by the provider and approved by the coalition. A special needs rate shall be reimbursed for a school readiness child that has a documented physical, mental, emotional, or behavioral condition that requires a higher level of care in the child care setting. The special need child's condition must be validated by a licensed health, mental health, education or social service professional other than the child's parent or person employed by the child care provider."

**INSTRUCTIONS:** Complete this form and submit it to the **Inclusion Specialist (QI Department)** for review and approval of special rate. You will be notified in writing within **ten (10) business days** of final decision. **Attach all required back-up documentation to this form.**

**Provider Site Name:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_\_) \_\_\_\_\_

**Email:** \_\_\_\_\_@\_\_\_\_\_

### Child Information:

**Child Full Name:** \_\_\_\_\_ **Child Date of Birth:** \_\_\_\_\_

**Initial Enrollment Date at Childcare Provider:** \_\_\_\_\_

### Complete ALL areas below:

**Please attach back-up documentation for all boxes checked below:**

Child has an active Individualized Education Plan (IEP) (attach a copy to form)

Child has a diagnosed disability as determined and documented by a licensed health, mental health, education or social service professional

**ENSURE YOU COMPLETE AND SUBMIT THE SECOND PAGE OF THIS FORM**



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Use a separate line for each additional service provided above School Readiness Contractual Requirements, see example below. For service providers who offer outside therapies, attach back up documentation.

Additional Service Provided to Child above:	Frequency:	Who provides this service?
<i>Example:</i> Childcare staff are required to change diaper of school aged child while in care throughout the day.	<input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Teacher <input type="checkbox"/> Director <input type="checkbox"/> Specialized staff hired by provider <input type="checkbox"/> Other:
	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Teacher <input type="checkbox"/> Director <input type="checkbox"/> Specialized staff hired by provider <input type="checkbox"/> Other:
	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other:	<input type="checkbox"/> Teacher <input type="checkbox"/> Director <input type="checkbox"/> Specialized staff hired by provider <input type="checkbox"/> Other:

**ELCMC Official Use Only:**

All required back-up documentation received:  Yes  No

Request Approved

Request Denied Reason for Denial:

\_\_\_\_\_

\_\_\_\_\_  
ELCMC Inclusion Specialist or Designee Signature

\_\_\_\_\_  
Date