County Case #: _____ **Return Form To:** _____

SUPPLPLEMENTAL PAYMENT
PROVIDER INFORMATION FORM

To obtain the supplemental payment, the child has to be identified as a child with special needs by the regional Children's Developmental Services Agency (CDSA) or local education agency (LEA) or if applicable the Local Management Entity (LME) or local public health department (PHD). 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 Approval of Supplemental Rate form. 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 not licensed 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 Children's Developmental Services Agency, local education agency, local management entity, local public health department: In order to receive payment for the supplement, the provider must complete the Provider Section of DCDEE-0454B and return to the local DSS or LPA. The local DSS or LPA completes the section below indicating the approval of the supplement and keeps the original. The local DSS or LPA returns the copy to the provider and a copy to CDSA, LEA, LME, or the PHD. A completed copy of the form, Child with Special Needs Additional Expense Documentation (DCDEE-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: _____