Child Care Inclusion Program Application

Inclusion Application Type:	☐Initial	☐Renewal	☐Amendment	☐Annual

Section A: Child Care Service Information

Child Care Service Name:					
Administrator:					
Licensee:					
Street Address:		**City/Town:**		**Province:** NL	**Postal Code:**
Telephone:		**Email:**			
Region:	☐Metro	☐Central East	☐Western	☐Labrador	
OGP Site:	☐Yes ☐No	**Using Provincial Wage Grid:**	☐Yes ☐No – **if no, attach wage grid**		

Section B: Licensing Information

Type of Program:	☐Full Time ☐Part Time	**Hours Of Operation:**			
Days of Operation (Check all that apply):	☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐ Friday ☐Saturday ☐ Sunday				
Service Capacity:		**Number Enrolled:**		**Service Age Range:**	
Administrator in Ratio:	☐ Yes ☐ No	If No, Explain:			

Section C: Required Documentation

The following Documentation must be attached (if applicable):

☐Signed Consent Form	☐Centre's Current License
☐Observation Charts/Records (if applicable)	☐Professional Referral Letter (if applicable)
☐Inclusion Policy	☐ Wage Grid, if not using Provincial Wage Grid

Section D: Request Details:

Are there any existing approved supports in place at the Child Care Service? ☐Yes ☐No

Approved Support:	**Applicable Homeroom (s):**
☐Consultative	
☐Professional Learning/Replacement Staff	
☐Funded Space	
☐Staffing Grant	

Have you consulted with a Child Care Consultant and/or Social Worker for direction/support? ☐ Yes ☐ No

Newfoundland & Labrador

Child Care Inclusion Program Application

Section E: Application Details **Table 1 - Consent and Support: Compete for each child with identified support needs.**				
Child Initials and DOB	**Consent Attached**	**Date Child Started at Service**	**Current Supports in Place**	
Initials: Date of Birth: yyyy/mm/dd	☐Yes	yyyy/mm/dd ☐not yet started	☐ISSP or IPP	☐ Physiotherapist
			☐ Pediatrician	☐ Direct Home Service Program
			☐ Regional Autism Services	☐ Speech Language Pathologist
			☐ K-12 Supports	☐ Behavior Management Specialist
			☐ Occupational Therapist	☐ Children Seniors and Social Development
			☐ Professional Referral	☐ Care Plan as per Child Care Policy and Standards Manual
			Other:	
Child Initials and DOB	**Consent Attached**	**Date Child Started at Service**	**Current Supports in Place**	
Initials: Date of Birth: yyyy/mm/dd	☐Yes	yyyy/mm/dd ☐not yet started	☐ISSP or IPP	☐ Physiotherapist
			☐ Pediatrician	☐ Direct Home Service Program
			☐ Regional Autism Services	☐ Speech Language Pathologist
			☐ K-12 Supports	☐ Behavior Management Specialist
			☐ Occupational Therapist	☐ Children Seniors and Social Development
			☐ Professional Referral	☐ Care Plan as per Child Care Policy and Standards Manual
			Other:	
Child Initials and DOB	**Consent Attached**	**Date Child Started at Service**	**Current Supports in Place**	
Initials: Date of Birth: yyyy/mm/dd	☐Yes	yyyy/mm/dd ☐not yet started	☐ISSP or IPP	☐ Physiotherapist
			☐ Pediatrician	☐ Direct Home Service Program
			☐ Regional Autism Services	☐ Speech Language Pathologist
			☐ K-12 Supports	☐ Behavior Management Specialist
			☐ Occupational Therapist	☐ Children Seniors and Social Development
			☐ Professional Referral	☐ Care Plan as per Child Care Policy and Standards Manual
			Other:	
Child Initials and DOB	**Consent Attached**	**Date Child Started at Service**	**Current Supports in Place**	
Initials: Date Of Birth: yyyy/mm/dd	☐Yes	yyyy/mm/dd ☐not yet started	☐ISSP or IPP	☐ Physiotherapist
			☐ Pediatrician	☐ Direct Home Service Program
			☐ Regional Autism Services	☐ Speech Language Pathologist
			☐ K-12 Supports	☐ Behavior Management Specialist
			☐ Occupational Therapist	☐ Children Seniors and Social Development
			☐ Professional Referral	☐ Care Plan as per Child Care Policy and Standards Manual
			Other:	

Child Care Inclusion Program Application

Table 2: Home/Homeroom Details. Complete for EVERY homeroom. (Indicate ☒ where supports are being requested). Make sure information reflects current license.																		
Details:	**☐FCC or ☐ HR1**		**☐ HR2**		**☐ HR3**		**☐ HR4**		**☐ HR5**		**☐ HR6**		**☐ HR7**		**☐ HR8**		**☐ HR9**	
Certification Level & Classification of FCC Provider or HR Lead Caregiver	☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered	
Certification Level & Classification of Second Caregiver	☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered	
Certification Level & Classification of Additional Caregiver ☐Not yet Hired	☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee______ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee _____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee______ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee______ ☐Waivered		☐L1- ______ ☐L2- ______ ☐L3- ______ ☐L4-______ ☐Trainee_____ ☐Waivered	
Age Range																		
Staff to Child Ratio																		
Capacity																		
Number of Spaces Filled	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Complete for Children with support needs where support is requested as well as those in place	Initials	Age	Initials	Age	Initials	Age	Initials	Age	Initials	Age	Initials	Age	Initials	Age	Initials	Age	Initials	Age

Child Care Inclusion Program Application

Section F: Identified Areas of Support – please check all applicable categories		
Reason For Request Inclusion Supports	**Applicable Child Initials**	**Strategies Attempted to address Inclusion Challenges (training, accommodations, modifications to the environment/equipment/program schedule)**
☐**Physical:** ☐Mobility/Accessibility Devices **Type**:_____ ☐ Gross Motor ☐ Fine Motor		
☐ **Social/Emotional:** ☐ Regulation ☐ Peer interactions ☐ Social Skills ☐ Play Skills ☐ Problem solving		
☐ **Behavior/safety:** ☐ Self-injurious ☐ Physical Aggression: ☐**Hitting** ☐**Kicking** ☐**Biting** ☐**Other:** _____ ☐ Repetitive behaviors ☐ Elopement ☐ Transitions ☐ Impulsivity/Hyperactivity ☐ Attention/Focus		
☐ **Self-Help:** ☐ Toileting ☐ Dressing ☐ Feeding		
☐ Environmental triggers ☐ Sensitivities (e.g. touch, tastes, textures) **Briefly describe environmental triggers/sensitivities:**		
☐**Language:** ☐ Expressive language (verbal) ☐ Receptive language (comprehension) ☐ English as an alternate language ☐ Use of augmentative or alternate communication **Type**: _____		
☐ **Other (please explain):**		
Is there training that the Service/Homeroom would find beneficial? If so, explain training needs:		

Child Care Inclusion Program Application

Section F: Continued	
What Type of Support is the Service seeking?	**How will the Service Use the Supports?**
☐Consultative	
☐Professional Learning/Replacement Staff	
☐Staffing Grant	
☐Funded space	

Section G – Signature

I, the undersigned, do hereby certify that all of the information provided on this form, including supporting documentation, is accurate and true to the best of my knowledge.

Licensee/FCC Provider/ Authorized Designate Signature: _____ **Date:** _____
YYYY/MM/DD

Name (Please Print) _____

FOR OFFICE USE ONLY:

Received By:		**Date Received YYYY/MM/DD**	
Assigned to		**Date Assigned YYYY/MM/DD**	

PRIVACY NOTICE

The information collected on this form is collected under the authority of the *Child Care Act* and the *Access to Information and Protection of Privacy Act (ATIPPA)* and is used solely for the purposes of administration/operation of regulated child care program and services provided by the Early Learning and Child Development Division. This information is kept confidential and held securely as required by *ATIPPA*. If you have any questions about the collection or use of this information, please contact the Information Management Division of the Department of Education at 709-729-6281.