CFWB-001
REV. 01/23

NYC Children

Special Needs Application

All sections must be filled in or the application will be considered incomplete.
Families utilizing this form must be eligible for subsidized child care.

Please return application and supporting documents to:

NY ECPDI, Attn.: Special Needs Review Unit, P.O. Box 24988, Brooklyn NY 11202

Fax: 646-664-3947 **Email: SNRU@earlychildhoodny.org**

Section 1: To be Completed by Parent

Please check (√) one: ◯ New Request ◯ Renewal ◯ Change of Provider ◯ Appeal

Parent Information

Parent/Caretaker's Name **(please print)** _____

Primary Language: _____ Email Address: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Child Information

Child's Name **(please print)** _____ Child Care Case Number: _____

Cash Assistance Case Number **(if applicable)**: _____ Date of Birth: _____

Child Care Program/Provider Information

Child Care Program/Provider Name **(please print)** _____

Current Address: _____ Email Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Provider ID #

Section 2: Application Type

◯ Special Needs Care	◯ Special Needs Care and Enchanced Payment Rate
If you are applying for special needs care only, you are applying for your child care case to be designated as a Special Needs Case without an enhanced payment rate.	If you are applying for special needs care with an enhanced payment rate, you are applying for special needs care and enhanced payment rate for the provider listed in Section 1.

Section 3: Attestation and Signature to be Completed by Parent

I swear and/or affirm that all information I have provided is true and accurate.

_____ _____

Parent/Guardian Signature **Date**

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Section 4: To Be Completed by one of the following: Physician, Licensed or Certified Psychologist, Special Education Teacher, or Therapist.

The above treating professional of the child requiring special needs child care must use the space below OR provide a separate letter describing the child's treatment of their special needs. Documentation of diagnosis from the treating professional is also required and must be attached to the application. The letter, documentation and all other applicable documents must be on letterhead and dated within one calendar year of the submission of this application.

Name **(please print)** _____

Current Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Cell Phone: _____ Email Address: _____

Title: _____ NYS License No: _____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Section 5: Signature to be Completed by Treating Professional

I swear and/or affirm that all information I have provided is true and accurate.

_____ _____
Treating Professional Signature **Date**

Section 6: For Office Use Only

Date Recieved: _____

_____
Staff Name

_____
Staff Signature