Newfoundland Labrador

Child Care Inclusion Program Application

Inclusion Request:	◯ Initial	◯ Renewal	◯ Amendment

Section A: Child Care Service Information

Child Care Service Name					
Administrator(s)					
Licensee					
Street Address					
City/Town		Province	**NL**	Postal Code	
Telephone		E-Mail			
Region	◯ Metro ◯ Central East ◯ Western ◯ Labrador	OGP Site	◯ Yes ◯ No		

Section B: Licensing Information

Type of Program	◯ Full Time ◯ Part Time		
Hours of Operation			
Days of Operation CHECK ALL THAT APPLY	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Saturday		
Service Capacity		Number Enrolled	Administrator in Ratio ◯ Yes ◯ No **(if no - explain details in the "Additional Information" section)**
Service Age Range			

Section C: Application Details

Table 1 - Consent & Supports: Complete for each child with identified exceptionalities

Child Initials and DOB	Consent Received	Date Child Started at Service	Current Supports in Place	
Initials DOB yyyy/mm/dd	☐ Yes	☐ not yet started	☐ ISSP or IPP ☐ Pediatrician ☐ Regional Autism Services ☐ K-12 Supports ☐ Occupational Therapist ☐ Other :__________	☐ Physiotherapist ☐ Direct Home Services ☐ Speech-Language Pathologist ☐ Behaviour Management Specialist ☐ Children, Seniors and Social Development
Initials DOB yyyy/mm/dd	☐ Yes	☐ not yet started	☐ ISSP or IPP ☐ Pediatrician ☐ Regional Autism Services ☐ K-12 Supports ☐ Occupational Therapist ☐ Other:__________	☐ Physiotherapist ☐ Direct Home Services ☐ Speech-Language Pathologist ☐ Behaviour Management Specialist ☐ Children, Seniors and Social Development
Initials DOB yyyy/mm/dd	☐ Yes	☐ not yet started	☐ ISSP or IPP ☐ Pediatrician ☐ Regional Autism Services ☐ K-12 Supports ☐ Occupational Therapist ☐ Other:__________	☐ Physiotherapist ☐ Direct Home Services ☐ Speech-Language Pathologist ☐ Behaviour Management Specialist ☐ Children, Seniors and Social Development
Initials DOB yyyy/mm/dd	☐ Yes	☐ not yet started	☐ ISSP or IPP ☐ Pediatrician ☐ Regional Autism Services ☐ K-12 Supports ☐ Occupational Therapist ☐ Other:__________	☐ Physiotherapist ☐ Direct Home Services ☐ Speech-Language Pathologist ☐ Behaviour Management Specialist ☐ Children, Seniors and Social Development

Table 2 – Home/Homeroom Details

Family Child Care (FCC)/Homeroom (HR) Information - Compete for EVERY homeroom (Indicate ☒ where supports are being requested)																		
Details	☐ **FCC or** ☐ **HR1**		☐ **HR2**		☐ **HR3**		☐ **HR4**		☐ **HR5**		☐ **HR6**		☐ **HR7**		☐ **HR8**		☐ **HR9**	
Certification Level & Classification of FCC Provider or HR Lead Caregiver																		
Certification Level & Classification of Second Caregiver																		
Certification Level & Classification of Additional Caregiver																		
Age Range																		
Caregiver to Child Ratio																		
Capacity																		
Number of child care spaces filled	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
Complete for children with exceptionalities enrolled in FCC/HR where support is requested, as well as those already in place	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**	**initials**	**age**

Section D: Request Details (See guide to completion)

Have you referred the family for any of the supports listed in Table 1 or others not listed? ☐ Yes ☐ No
(if "Yes" please provide details)

Has a written care plan been developed in conjunction with the parents/guardians as outlined in section ELCD- 2017-K1 of the Child Care Policy and Standards Manual? ☐ Yes ☐ No (Note: This is not an IPP)

Are there existing supports in place at the child care service? ☐ Yes ☐ No

If "Yes", please provide details of existing supports (e.g., homeroom, type of support, approval period):

Have you consulted with a child care and/or an inclusion consultant for direction/support? ☐Yes ☐ No

Describe the strategies implemented to date to foster an inclusive environment and address the current inclusion challenge and why these modifications are not enough to support the identified child(ren) (including training, accommodations/modifications to the environment/equipment/program/ schedule).

What are the presenting concerns and why is inclusion support requested? (indicate if the support is requested prior to the child/children beginning in the program and if written consent and professional referral(s) are attached)

Developmental Concerns:

Safety/Supervision:

Behaviour Affecting Programming:

How will this support be used within the home/homeroom to include all children in attendance and address the concerns noted in the previous questions?

Additional Information - Where the Administrator is not in ratio, details of why the Administrator is not able to assist in providing the extra support needed must be included in this section.

Section E – 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) _____

Section F – Required Documentation

The following Documentation must be attached **(if applicable)**:

1. Written Consent
2. Professional Referral Letter
3. Observation Charts/Records
4. Inclusion Policy

FOR OFFICE USE ONLY

Received By _____ Date Received YYYY/MM/DD _____

Assigned to _____ Date Assigned YYYY/MM/DD _____

PRIVACY NOTICE

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