State of Nevada | Division of Welfare & Supportive Services | Child Care and Development Program

Child & Youth with Special Health Care Needs Level of Care Screener

Child's Name: _____ DOB: _____

Child's Unique Personal Identifier (UPI) Number: _____

Parent(s)/Guardian(s) Name(s): _____

Parent(s)/Guardian(s) Unique Personal Identifier (UPI) Number: _____

Address: _____

Phone Number: _____ Alt. Phone Number: _____

Email Address: _____

This document is for informational purposes to detail the intensity of care that is needed for this individual child or youth and should *not* be used to document the child's or youth's medical condition(s) or how to properly care for him/her/them. This document must be completed by the child's or youth's parent(s)/guardian(s). Eligibility is valid for twelve (12) months from the date of approval. Should the level of care (tier) increase (e.g., from a Tier I to a Tier II), any payment adjustments to the child care provider will be reflected in the next month's payment to the child care provider.

Rating Scale: Each criterion must be rated on a scale of zero (0) to five (5), with five (5) being the highest frequency and intensity of need.

0 = No Impact
1 = Minimal
2 = Minimal to Moderate
3 = Moderate
4 = Moderate to Intensive
5 = Intensive

Medication: The child or youth takes medication (one or multiple) at varying times of the day.	
Growth Delays: The child or youth has developmental delays and may be in a rehabilitative program including but not limited to speech therapy, physical therapy, and/or occupational therapy.	
Requires Assistance with Self-Care: The child or youth requires ongoing assistance with routine daily activities (e.g., toileting, eating, etc.).	

Seizures: The child or youth experiences seizures which require ongoing medication and/or training should one occur. • If so, frequency: _____	
Behavioral Needs: The child or youth has extraordinary behavioral needs that require including but not limited to constant supervision, redirection, and/or interaction with staff. The child may be at risk of being suspended and/or expelled from child care (or has been in the past). • If the child has been previously suspended due to behavioral needs, please explain briefly: _____ _____	
Dietary Needs: The child's or youth's feeding needs demand assistance with feeding for extended periods of time for each meal/snack and/or the use of external medical equipment such as a g-tube.	
Mobility Assistance: The child or youth needs assistance with mobility including but not limited to a wheelchair, walker, blindness (visual impairments) etc.	
Medical Care: The child or youth requires specialized, daily, and routine medical care including but not limited to the application of topical creams and/or lotions, complex medication(s) management/ distribution, insertion/replacement of feeding tube, physical therapy, and/or occupational therapy routines.	
Medical Equipment: The child or youth requires Durable Medical Equipment (DME).	
Storage for Medical Equipment: The child or youth has medical equipment that requires storage when not in use to ensure it is not damaged.	
Other: Please Describe.	
Total Score	

☐ _____ (Initials) I attest that the information provided is true and accurate to the best of my knowledge, ability, and belief and that the child/youth identified above has a medical diagnosis for a special health care need.

☐ _____ (Initials) I consent that my contact information (e.g., name, phone number, email address, and child care business address) can be shared with the Early Childhood – Community Health Worker Program, NEIS, and IDEA Part C (if applicable) as part of my on-going participation in this CYSHCN Slots Pilot Program.

Print Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Print Child Care Provider Name: _____

Child Care Provider's Signature: _____ Date: _____

Child Care Provider Business Name: _____

For Internal Use Only

CCR&R Office: ☐ *The Las Vegas Urban League* ☐ *The Children's Cabinet*

Print Staff Name: _____ Title: _____

Staff Signature: _____ Date Received: _____

Verification of Special Health Care Need: ☐ Yes ☐ No Date Verified: _____

The Child Care & Development Program:

Print Staff Name: _____ Title: _____

Staff Signature: _____ Date Received: _____

Scoring Rubrik:	*Child or Youth's Qualified Tier:*
Tier I Score = 18 or Below	☐ Tier I
Tier II Score = Between 19 and 36	☐ Tier II
Tier III Score = 37 or Greater	☐ Tier III

Decision: ☐ Approved ☐ Denied

Month Rate Effective: ☐Jan ☐Feb ☐Mar ☐April ☐May ☐June ☐July ☐Aug ☐Sept ☐Oct ☐Nov ☐Dec

Rate Approved Through: September 30, 2024

Child & Youth with Special Healthcare Needs Staff Member Bonus Acknowledgement

Due to the enhanced reimbursement rate each for the CYSHCN Slots Pilot Program, one of the requirements is that the teacher(s) working with the child (as identified on page one of this screener), are entitled to a monthly bonus for each month the slot is occupied throughout the duration of this pilot program. For the purposes of this pilot program, "teacher" is defined below:

- A teacher is defined as a child care staff member who consistently engages with a child or youth possessing special health care needs. This individual is engaged in a minimum of fifty (50) percent of the child or youth's daily schedule in the care program to foster their well-being and development. This involves actively participating in the child or youth's personal care routines, interactions, educational activities, and any accommodations essential to cater to their developmental needs. This role entails a regular and committed involvement with the child or youth to ensure their holistic care and successful integration into the child care environment.

Based on approved Level of Care (Tier), the monthly bonus to each teacher that meets the above definition is entitled to a monthly bonus in the following amounts:

- Tier I: $500*
- Tier II: $700*
- Tier III: $900*

  *If there are multiple teachers that work with the child or youth, the designated bonus amount is to be split among them equally. This bonus is 20% of the entire amount that was reimbursed to the provider for the qualified tier.

I acknowledge that as part of this pilot program, the following teacher(s) will be working with the CYSHCN identified in this screener and will be paid the monthly bonus.

Print Teacher Name	Teacher Signature	Date
Print Teacher Name	Teacher Signature	Date
Print Teacher Name	Teacher Signature	Date

If you believe you are not receiving that monthly bonus, please contact The Child Care & Development Program at ccpd@dwss.nv.gov.