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

Children & Youth with Special Health Care Needs (CYSHCN) Quality Improvement Grant Application

Child Care Provider General Information		
Name of Person Completing Form:	Title:	
Name of Director:	Name of Business Owner:	
Name of Child Care Business on License:		
Physical Address:	City:	Zip:
Mailing Address:	City:	Zip:
Phone:	Alt Phone:	E-mail:
Preferred Method of Communication: ❒ Phone ❒ Email		
Has your program been approved to participate in the CYSHCN Slots Pilot Program?	❒ Yes	❒ No

Support for Quality Environments for Children & Youth with Special Health Care Needs

Please indicate what items you need to expand your Children & Youth with Special Health Care Needs slots and/or meet the requirements of the pilot program. We do not need item numbers and vendor names at this time. This is a preliminary request of the items you will need to maintain and/or increase your capacity with this population.

Item Name	Quantity	Justification	Estimated Cost
TOTAL			

Certification & Signature

By signing this application, you certify that the signatory below is authorized to complete this application on behalf of the child care program. Additionally, the signatory understands that if approved, the Children & Youth with Special Health Care Needs (CYSHCN) slot(s) must be filled by a subsidy-eligible child. By signing the application, you confirm that the information provided is true, accurate, and was completed to the best of your knowledge.

Signature of Authorized Signer	Printed Name and Title of Authorized Signer	Date