**DEPARTMENT OF CHILD AND FAMILIES**
Division of Early Care and Education
Milwaukee Early Care Administration

# Certification Special Needs Exception

Certified Child Care by Milwaukee Early Care Administration

**Use of form:** This form is to be used by ALL Certified Child Care Operators in Milwaukee County who wish to care for a child with special needs over 12 years of age. This form is to be submitted to the certifying agency and is in compliance with DCF 202.08(6). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay.

## Provider Information

| Date Form Completed | Provider Number |
|---|---|
| Name – Child Care Operator (Last, First, MI) | Tax ID / Social Security Number |
| Start Date for Child Care | |

## Family Information

| Name – Parent (Last, First, MI) | Telephone Number |
|---|---|
| Name – Child (Last, First, MI) | Date of Birth |

Describe special needs:

☐ Yes ☐ No Does child require one-on-one care while in child care setting?

Describe plan to accommodate child's special needs:

Submit completed form to certifier or certification agency: Milwaukee Early Care Administration: 1220 West Vliet Street, 2nd Floor , Milwaukee, WI 53205 or Fax to (414) 289-5848. You can also drop this form off at the above address during business hours of 8:00 am – 4:30 pm, Monday through Friday. If you have any questions concerning this form contact your certifier.

**SIGNATURE** – Provider Completing the Form _____ Date Signed _____

## FOR DEPARTMENT USE ONLY

| Certification Specialist Action: | Time Limited? | Review at Certification Renewal: |
|---|---|---|
| ☐ Approve | ☐ Yes – Expiration Date: _____ | Review Date: _____ |
| ☐ Deny | ☐ No | Review Date: _____ |
| | | Review Date: _____ |

Reason for Action – Specify.

Conditions – Specify.

**SIGNATURE** – Certification Representative _____ Certification Representative Title / Position _____ Date Signed _____

**CERTIFICATION AGENCY: APPROVED FORM MUST BE FORWARDED TO COORDINATOR FOR SPECIAL NEEDS, T: (414) 289-6977, F: (414) 289-6179 and copies to MECA Certification Supervisor for certification to be adjusted.**