

**KRC DAYCARE WORKSHEET
CONFIDENTIAL (FOR KRC USE ONLY)**

Service Coordinator: _____ *Phone extension:* _____

Date: _____

Name: _____ **DOB:** _____ **Client Age:** _____ **UCI:** _____

Diagnosis: *Intellectual Disability: Mild Moderate Severe Profound Autism CP Epilepsy*
 Borderline Intellectual Level of Functioning/ 5th Category Provisional Eligibility(ages 3-4)

FCPP Assessment: Yes (If yes, amount of co-pay) N/A

Has Medi-Cal: Yes: No: **IHSS:** Yes No (If yes # of Hours) _____

PARENT PERSONAL DATA

	(Circle One) Father or Stepfather or Partner	(Circle One) Mother or Stepmother or Partner
Work Schedule		
Position/Occupation		
Employer		
Address		
City		
Phone		
Salary/Wages		
Other Income (please describe)		

Total Number of Family Members Including Client _____

Number of Hours Being Requested for Daycare _____

Amount Parent Is Paying for Daycare _____

Daycare Provider _____

SPECIAL CONSIDERATIONS FOR DAYCARE REQUEST:

Approved by:

Daycare Reimbursement Rate:

Date of approval:

****ALL DAYCARE PURCHASE OF SERVICES MUST BE REVIEWED ON YEARLY BASES AND CANNOT ROLL OVER