Continuity of Care Request for Funds

Early Learning
psesd
excellence & equity in education
Puget Sound Educational Service District

	PSESD Use **Number**:
Child: DOB:	Date of Enrollment:
Current Age:	Center/Home:
Parent(s): Parent's Monthly co-pay amount:	Provider/Center Director:

1. Describe situation:

2. Describe efforts made to find other resource(s) to support child care during this period:

3. List other sources and amounts of funding that will be used to support continued child care, in addition to parent's co-pay (i.e., other agencies, parent contribution):

4. Describe plans and timeline for restoring subsidy or family's ability to pay for child care:

5. Will part day or part week child care meet the child/family needs during this interim period? ☐ Yes ☐ No
If Yes, please provide interim child care schedule approved by Center Director:

6. *WCCC rate ☐ or private rate ☐ of ________, total number of days for this request _____ from ___/___/___ to ___/___/___

*Max: 10 school days per request. You can contact ESD to extend the request 10 days at a time, if needed.		Child care in a licensed or certified **child care center**			Child care in a licensed or certified **family home** child care		
		Infant	Toddler	Preschool	Infant/Toddler	Toddlers	Preschool
		(1 – 11 months)	(12 - 29 months)	(30 months – 5 years)	(1 – 17 months)	(18 – 29 months)	(30 months – 5 years)
King County	full-day	$52.94	$44.20	$37.10	$54.37	$45.31	$40.78
	half-day	$26.47	$22.10	$18.55	$27.19	$22.66	$20.39
Pierce County	full-day	$38.82	$33.41	$29.40	$37.07	$32.23	$27.19
	half-day	$19.41	$16.71	$14.70	$18.54	$16.12	$13.60

Family Support Staff Signature	Date

PSESD use only:

☐ **Request Approved:**
PSESD will reimburse ____

____

Rate $________ per day x # of_____ days = __________ - __________ = $ ____________
(other resources)

NOTE: 45 days is the maximum number of days of continuity of care will be approved and funded for one child in program year.

Number of days previously requested

Maximum Reimbursement: $_____________

Approved dates: _______ /_______ /_______ to _______ /_______/________

☐ **Request Not Approved –** Family Support or Provider will proceed with alternative plan.

Family Engagement Coach Signature		Date	
Team Manager or ERSEA Coordinator Signature		Date	
Program Director Initial	Date	Logged in by HS Fiscal	Date