**State Intermediate Educational Unit**

**146 State House Station, Augusta, ME 04333**

Telephone: (207) 624-6660

Fax: (207) 624-6661

<http://www.maine.gov/doe/learning/cds>

**Early Childhood Special Education Program**

***\*This is the first step in the program approval process. Once complete you will hear from our contract department\****

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Program Name | |  | | | | | | | Date | | |  | | | | | |
| Program Administrator | |  | | | | | | | Email | | |  | | | | | |
| Physical Address | |  | | | | | | | Phone | | |  | | | | | |
|  | |  | | | | | | | Fax | | |  | | | | | |
| Mailing Address  (if different than above) | |  | | | | | | | | | | | | | | | |
| Check one of the following | | **This is a new program  This is my yearly update-no changes**  **I am updating program information (tell us more below\*)** | | | | | | | | | | | | | | | |
| Briefly describe what information you are updating. \* | | \*Only complete the section(s) that require updated or new information\* | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Legal Status/ Organization** | | | | | | | | | | | | | | | | | |
| Name of Corporation | | | |  | | | | | | Date of incorporation | | | | |  | | |
| Preschool/ Program must be incorporated under the laws of the State of Maine or the United States to receive public funds. **Attach** a copy of legal incorporation documents if not currently on file at the CDS State IEU. | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Program Fiscal Information** | | | | | | | | | | | | | | | | | |
| Do you bill MaineCare for services referred for by IFSP/IEP? | | | | | | | | | | | Yes  No | | | Section 28 | | Yes  No | |
|  | | | | | | | | | | |  | | | Section 65 | | Yes  No | |
| Do you bill private insurance for services referred for by IFSP/IEP? | | | | | | | | | | | Yes  No | | | NPI #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Must include brochure/ handbook information that references usual and customary rates, if rates established. | | | | | | | | | | | | | | | | | |
| On file | Included | | Available electronically at | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Program Information** | | | | | | | | | | | | | | | | | |
| Child Care License Information | | | | | | License ID # |  | | | | | | Capacity | | | |  |
| Describe the programs Inclusion Practices. | | | | | |  | | | | | | | | | | | |
| Describe the Programs Curriculum. | | | | | |  | | | | | | | | | | | |
| Describe the ongoing assessment that occurs for all children in the program. (attach a sample) | | | | | |  | | | | | | | | | | | |
| Describe the Programs Behavior Management Procedures (attach documentation) | | | | | |  | | | | | | | | | | | |
| Describe how progress is measured and how data is collected. (attach data collection sample) | | | | | |  | | | | | | | | | | | |
| What accommodations/ modifications are used to support a child’s individual developmental needs? | | | | | |  | | | | | | | | | | | |
| Describe supervision procedures for educational technicians? (attach sample documentation template) | | | | | |  | | | | | | | | | | | |
| Is the program accredited by a national organization? | | | | | Yes  No | If yes, describe? | |  | | | | | | | | | |
| Do you currently have QRIS Certificate/ Level? | | | | | Yes  No | If yes, what step? | |  | | | | | | | | | |
| Is the program fully accessible? | | | | | Yes  No | If no, explain | |  | | | | | | | | | |

Program Name:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Preschool Classroom Profile (one classroom per profile; use additional pages if needed)** | | | | | | | | | | | | | | | | | | | | | | |
| Preschool Classroom Name | | |  | | | Regular Early Childhood Education Setting (RECS) | | | | | | | Ratio |  | | | | | | | | |
|  | | |  | | | Special Education Classroom Setting (SECS) | | | | | | | 4:1 | | | 3:1 | | | 2:1 | | | 1:1 |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Preschool Education Session Description** (**indicate the time where educational opportunities are occurring**) | | | | | | | | | | | | | | | | | | | | | | |
| Day | Monday | | | Tuesday | | | | Wednesday | | | | Thursday | | | | | | Friday | | | | |
| Time |  | | |  | | | |  | | | |  | | | | | |  | | | | |
| Describe Classroom. | | | |  | | | | | | | | | | | | | | | | | | |
| Describe daily classroom schedule (or attach). | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Staff Information**  (All staff must have certification/ authorization from the Department of Education.) | | | | | | | | | | | | | | | | | | | | | | |
| Lead Teacher | | |  | | | | | | Certification |  | | | | | | | Issued | | | |  | |
|  | | |  | | | | | |  |  | | | | | | | Expires | | | |  | |
| Supervisor | | |  | | | | | | Certification |  | | | | | | | Issued | | | |  | |
|  | | |  | | | | | |  |  | | | | | | | Expires | | | |  | |
| Educational Administrator | | |  | | | | | | Certification |  | | | | | | | Issued | | | |  | |
|  | | |  | | | | | |  |  | | | | | | | Expires | | | |  | |
| **Additional Classroom Staff** | | | | | | | | | | | | | | | | | | | | | | |
| Name | | Position | | | Certification/  Authorization | | Issued/ Expired | | | | Supervisor | | | | Employee Signature | | | | | | | |
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| **I hereby attest that appropriate staff and I have read and understand the following and will abide by them to the best of our ability when providing services to children referred to our program.** | | | |
|  | Lead Teacher Signature | Educational Administrator | Supervisor Signature |
| Maine Unified Special Education Regulations (MUSER) |  |  |  |
| Individuals with Disabilities Education Act (IDEA) |  |  |  |
| Family Education Rights and Privacy Act (FERPA) |  |  |  |
| Chapter 33 Rule Governing Physical Restraints and Seclusion |  |  |  |

*Attachment I:*

**PROGRAM APPROVAL**

**Education Administrator Amendment**

**PROGRAM NAME:**

**Educational Administrator Name:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Education Administrator Requirements: | | | | | | | | |
| Certification as a Special Education Administrator (030) or **ALL** of the following: | | | | | | | | |
| * One of the listed Certification through the Maine Department of Education | | | | | | | | |
| 035 Assistance Special Education Director | | | | 079 Special Education Consultant | | | | 093 School Psychological Service Provider |
| 282 Teacher of Students with Disabilities  B-5 | | | | 286 Teacher- Severe Impairment | | | | 291 Teacher- Visual Impairments |
| 292 Teacher- Hearing Impairments | | | | 293 Speech and Hearing Clinician | | | |  |
| * Minimum of a Master’s Degree in Special Education or related field | | | | | | | | |
| * Minimum of one year Administrative Experience | | | | | | | | |
| ***If Education Administrator does not meet the above requirements***  ***one of the following requirements MUST be met:*** | | | | | | | | |
|  | Education Administrator is enrolled in a Masters Level Degree Program in Special Education or related field and needs less than 9 credit hours to complete their degree. | | | | | | | |
| School Enrolled | |  | | | | Degree Program | |  |
| # of credits earned | |  | | | | Anticipated Date of Program Completion | |  |
|  | | | | | | |  |  |
| Signature of person verifying amount of credits currently earned | | | | | | |  | Date |
| *Conditional program approval may be granted for one year only. The Education Administrator*  *referred to above must have their degree within one year of the application date.* | | | | | | | | |
|  | | | | | | | | |
|  | Education Administrator is enrolled in a Masters Level Degree Program in Special Education or related field and needs more than 9 credit hours to complete their degree. | | | | | | | |
| School Enrolled | |  | | | | Degree Program | |  |
| # of credits earned | |  | | | | Anticipated Date of Program Completion | |  |
|  | | | | | | |  |  |
| Signature of person verifying amount of credits currently earned | | | | | | |  | Date |
| To qualify for a limited provisional approval you must provide the Special Education Mentor/ Consultant who is assisting the Education Administrator. The mentor/ consultant must meet the Educational Administrator qualifications. Provide the following information: | | | | | | | | |
| Name | | |  | | | Employer | |  |
| Certification  (submit copy) | | |  | | | Years of Experience | |  |
| **Must complete Plan of Activities/ Assistance** | | | | | | | | |
| *Provisional approval may be granted for no more than 2 years.* | | | | | | | | |
|  | | | | | | | | |
|  | Program employs or consults with a Special Education Consultant that meets State of Maine Certification. | | | | | | | |
| Name | | |  | | | Certification  (submit copy) | |  |
| **Must complete Plan of Activities/ Assistance** | | | | | | | | |
| Amount of time spent with program and staff per month: | | | | |  | | | |

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| --- | --- |
| **Requirements:** | |
| - Consultant/ Mentor is available to applicant in case of any questions or needed guidance | |
| - Consultant/ Mentor reviews documentation and provides guidance to applicant in the supervision of program staff. | |
| Consultant/ Mentor Monitors for the following-   * High quality programming based on standards, curriculum and assessments * IFSP/IEP are strictly adhered to * Plans of Care/ Intervention Plans are appropriate and incorporate IFSP/IEPs goals * Billing for special education services are tied to plan | |
|  | |
| **Other Activities** (determined by program based on the needs of the applicant)**:** | |
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|  | |
| **Amount of time spent monthly working with applicant**:  (determine based on experience and need of applicant.) |  |

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| --- |
| **Consultant/ Mentor Plan of Activities/ Assistance** |

|  |  |  |
| --- | --- | --- |
|  | |  |
| Applicant Signature | | Date |
|  | |  |
| Consultant/ Mentor Signature | | Date |
| For Department Use Only | |  |
| Plan Approved | Plan **NOT** approved | |
| Comments/ Suggestions: | | |
|  | |  |
| State CDS Director or Designee Signature | | Date |