Early Learning and Child Care Program (ELCC)
Inclusion Support Program (ISP) Eligibility Application

RESET FORM

Manitoba

A. Applicant - Facility Information

Name of child care facility:	Facility Number:
Name of director/family child care provider:	
Phone:	Email:

B. Program Application and Eligibility Criteria

***Please note: The service a family receives under the Inclusion Support Program are subject to eligibility, assessed need and program resources available.**

Declaration of Consent

☐ I have received consent to release personal information and/or personal health information about the child and parent(s) or guardians for the purposes of determining program eligibility and service planning.

Please check the appropriate box (**only one**)

☐ The child receives supports through Children's disABILITY Services and/or has a formal diagnosis.

- Has a lifelong physical disability with significant functional limitations in mobility.
- Has been diagnosed with Autism Spectrum Disorder (ASD)
- Has lifelong, extreme and complex medical needs (URIS group A)
- Has demonstrated substantial delay in cognitive, physical, social, emotional and/or language development.

What is the child's primary diagnosis?

☐ The child exhibits behavioural or emotional difficulties characterized by, impaired adaptive functioning which disrupts the child's ability to adequately participate in programming and activities, and these behaviours continue over a period of time.

C. Child Information

Child's name:	Date of birth (dd/mm/yy) :
Is the child currently enrolled at the facility? ☐ Yes ☐ No	If "no", what is the targeted enrollment date? (dd/mm/yy) :

Type of space: ☐ infant ☐ preschool ☐ nursery school ☐ school age

D. Family Information

☐ **Parent** ☐ **Guardian/Agency (if applicable)**	☐ **Parent** ☐ **Guardian/Agency (if applicable)**
Daytime phone number:	Daytime phone number
Email address:	Email address:

Reason for child care:

☐ currently employed ☐ enrolled in a job skills training program ☐ enrolled at an educational institution

☐ seeking employment ☐ medical/special needs of the family ☐ CFS support plan

E. Application Authorization

☐ I declare that the information provided in this application is true and accurate.

Name of Director/Provider: Date (dd/mm/yy) :

F. For Office Use Only

☐ Approved ☐ Not approved ELCC Program Authorization: Date (dd/mm/yy) :