Dakota COUNTY | Social Services

Early Childhood Mini Grants for Young Children with Special Needs (SFY 2026-2027)

Grants are available for children under age three with special needs who receive Early Intervention Services through a Dakota County school district. Applications will be accepted starting October 26, 2026. Submit a completed application with supporting documents to SSECCoordinator@co.dakota.mn.us. Eligible applicants may receive up to $500 annually. Applications are reviewed in the order received; incomplete submissions will be denied but may be resubmitted. The program closes on June 11, 2027, or when funds are expended.

Only this current application version is accepted; previous versions will be returned.

All communication will be done via secure email unless an alternate means of communication is requested.

Things to consider when applying for grant funds:

- The child must receive Early Intervention Services through a Dakota County school. Dakota County residency alone is not sufficient.
- Families already receiving disability services such as Personal Care Assistant (PCA), Family Support Grant (FSG), Consumer Support Grant (CSG), Waivered Services, or Developmental Disability (DD) Case Management are not eligible for a grant.
- Request must be directly related to the child's special needs.
- This grant is only available after all other resources have been accessed or denied.
- Previous grant recipients must submit complete expenditure reports and/or receipts for previous grant expenses to SSECCoordinator@co.dakota.mn.us before an additional grant application will be accepted.

Grant funding may be used for the following purposes:

- Equipment used to help, maintain, or improve functional capabilities of a child.
- Specialized items (i.e., adaptive clothing, safety equipment), that are not typical costs of caring for a child of similar age.
- Short-term respite or temporary care to provide relief to the primary caregiver(s).
- Unreimbursed transportation fees (taxi, bus, Lyft/Uber) or mileage necessary to attend medical or mental health services.

The following documentation is required with each application submission:

- Current year application form, completed and signed by guardian/parent.
- Release of Information (ROI) that specifies an exchange of information with Dakota County Social Services.
- Individual Family Service Plan (IFSP).
- W-9 (required only if grant will be used for respite; substitute W-9's are not accepted).
- Attach documents individually. Combined PDF submissions cannot be separated for data retention compliance and will be denied.

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SFY 2026-2027 Application

1. Name of Child [First Middle Last]:

2. Child's Date of Birth [Month-Day-Year]:

3. Indicate the status for the child by indicating pending, denied, approved, or N/A for each service below:

Services	Application In Progress	Denied	Approved	N/A
A. Adoption Assistance				
B. Children's Mental Health Case Management Services				
C. Consumer Support Grant (CSG)				
D. Family Support Grant (FSG)				
E. Medical Assistance/ MnCHOICES				
F. MinnesotaCare				
G. Personal Care Attendant				
H. Private Insurance				
I. Private Duty Nursing				
J. Relative Caretaker Grant				
K. Rule 185 Developmental Disabilities (DD) Case Management Services				
L. Waivered Services				
M. Certified Disabled by Social Security Disability				
N. Certified Disabled by State Medical Review Team (SMRT) Review				
O. Tax Equity and Fiscal Responsibility Act (TEFRA)				

4. Please provide additional Information regarding participation or approval in any of the programs outlined above in question:

5. What School District does the child attend?

☐ ISD 6 – South St. Paul
☐ ISD 191 – Burnsville/Eagan/Savage
☐ ISD 192 – Farmington
☐ ISD 194 – Lakeville
☐ ISD 195 – Randolph
☐ ISD 196 – Apple Valley/Rosemount/Eagan
☐ ISD 197 – WSP/Mendota Heights/Northern Eagan
☐ ISD 199 – Inver Grove Heights
☐ ISD 200 – Hastings
☐ ISD 917 – Intermediate School District

6. Has the child been awarded the Early Childhood Mini Grant previously? If yes, all receipts must be submitted for the prior award before a new application will be considered.

☐ No ☐ Yes

7. Child's Diagnosis, Disability, Daily Functioning and Needs

- Complete EVERY box or minimally indicate not applicable (N/A) if an area does not apply to the child.
- **"Refer to IFSP" is not sufficient information**; please detail specifically the **impact** on daily living for the child and family.
- Please include any testing and scores as it relates to each area.

Diagnosis	Area of Concern and Impact on Daily Living for Child and Family
Medical Needs:	
Hearing and/or Visual Impairments:	
Feeding Concerns or Eating Issues:	
Seizures	

Diagnosis	Area of Concern and Impact on Daily Living for Child and Family
Gross Motor Skills:	
Communication Skills:	
Cognitive Delays:	
Sensory Issues:	
Adaptive Functioning:	
Social Emotional Development Intensity Scale (please indicate level): ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe	

8. Please list other community resources that have been explored prior to this application:

9. List the names and contact information for each parent/guardian:

Info	Guardian/Parent 1	Guardian/Parent 2	Guardian/Parent 3
Name of Guardian/Parent			
Relationship to Child			
Address			
Phone			
Email			

10. List names and ages of all children in the home (including the applicant), and indicate if any have a disability:

Child Name	Age	Disabled or Disability

11. Please list the names of all adults currently living in the home and indicate if any have a disability:

Adult Name	Disabled or Disability

12. Adjusted Gross Income from most recent 1040 or 1040A:

Please note there is no maximum income limit for this grant; information is needed for statistical purposes only. Please do not submit tax copies.

13. Please briefly describe the family's support system:

14. Family Functioning: Please indicate what other needs are impacting or stressing the family:

☐ Access barriers ☐ Low income ☐ Recent death in family
☐ Divorce ☐ Marital issues ☐ Sibling Issues
☐ Financial hardship ☐ Medical crisis or issues ☐ Single parenting
☐ Housing issues ☐ Mental health crisis or issues
☐ Lack of formal supports ☐ Other children with disabilities

15. Briefly describe how the factors checked in the question above impact the family:

16. List the item(s) or service being requested for this grant:

Item(s)	Purpose (as it relates to child's needs)	Cost

Respite Provider (Completion of W-9 is required for this service.)	Phone Number

17. If the application is approved, to which guardian or parent should the check be sent?

18. Grant recipients will be notified by secure email unless an alternate means of communication is requested. Please indicate the alternate means of communication that you are requesting.

19. School District or Public Health Service Coordinator

    Name:

    Title:

    School District:

    Phone:

    Email:

Agreement for Use of Grant Funding

I understand that I am responsible for planning for the services and purchasing the assistive technology tools requested or to hire, monitor, and pay for the services requested. I am responsible for completing and submitting an expenditure report to SSECCoordinator@co.dakota.mn.us once I have spent the grant funds, and I understand that I must keep the receipts for five years. I understand that I may be contacted by Dakota County for audit purposes and to ensure that government funds were used appropriately. I understand that I will be unable to apply for future grants unless an expenditure form or the receipts for this grant are provided to Dakota County.

Parent Signature: Date:

☐ By checking this box, I agree that I have communicated the expectations of this grant to the parent/caregiver prior to submitting the application on their behalf.

Service Coordinator Signature: Date