CK Child Care & Early Years

Municipality of Chatham-Kent
Child Care and Early Years
435 Grand Avenue West, P.O. Box 1230
Chatham, ON N7M 5L8
519.351.1228 x 2429
ckchildcare@chatham-kent.ca

Child Care Subsidy Therapeutic Referral Form

Required with Fee Subsidy application, which can be granted for those who are working, going to school or have a therapeutic need. An income test will be done to determine eligibility, plus reason for service.

*This form can be completed electronically and emailed to intake at **ckchildcare@chatham-kent.ca**, or mailed/dropped off to address above.*

Section A – Parent / Guardian to Complete

Parent/Guardian Information (to be completed by parent /guardian)		
Parent / Guardian #1 Full Name	*D.O.B (MM/DD/YY)*	*Phone Number*
Address		
Parent / Guardian #2 Full Name	*D.O.B (MM/DD/YY)*	*Phone Number*
Address		

Consent: By signing this form, the Parent/Guardian(s) consent to the release of this information to the Municipality of Chatham–Kent's Child Care and Early Years Division for the sole purpose of assessing initial and ongoing eligibility for Child Care Subsidy.

I, _______________________________ authorize ____ to provide the information requested on this form regarding my child's special or social needs to the Municipality Of Chatham Kent's Child Care and Early Years Division in order to determine eligibility for Child Care Subsidy.

____ ____________________________

Parent / Guardian Signature Date (DD/MM/YYYY)

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)(Municipal Freedom of Information and Protection of Privacy Act)
This information is collected under the legal authority of section 71 of the Child Care and Early Years Act, 2014, S.O 2014, c.11, Sched. 1 (the "Act") for the purpose of determining or verifying a person's eligibility to participate in a child care or early years program or service or to receive financial assistance under the Act. For more information contact: Supervisor – Early Years at **519-351-1228 ext. 2133**

Section B – Referring Agency / Health Care Professional to Complete

Contact Name of Referral Source:	
Title/Position:	Referral Agency:
Phone Number:	Email Address:
Length of time you expect to be working with this child/family and therefore request referral for:	

***Note:* A referral can only be granted for as long as you are working with the child/family but not more than 12 months.** Referrals are for 2 full days or 4 half days

Approved Professionals for referral sources: Physician, Nurse Practitioner, Public Health Nurse, CAS, Children's Treatment Centre, early intervention / Prevention Support Professionals. If the referring agency no longer provides supports to the child/family, please notify the Child Care and Early Years Division office at 519-351-1228 ext. 2429 or email at ckchildcare@chatham-kent.ca

Section B continued – Referring Agency / Health Care Professional to Complete

Parental Referral (If due to the parent's need) **Parent's/Guardian's Name:**			
Reason	**Suspected**	**Diagnosed /Confirmed**	**Comments / detailed reason for referral:**
Cognitive Impairment			
Mental Health			
Physical Limitations			
Family Crisis*			
Medical Need			
Other*			
Name(s) of child(ren) for which this parent referral applies:			

Child Referral (If due to the child's need)			
Child Full Name:			**Date of Birth:**
Child's Address:			
Child's Need – Please check ALL that apply			
Reason	**Suspected**	**Diagnosed /Confirmed**	**Comments / detailed reason for referral:**
Emergency-At-Risk*			
Family Crisis*			
Cognitive Impairment			
Physical Limitations			
Communicative Needs			
Developmental Needs			
Other*			

*If marked Emergency-At-Risk (physical, sexual, emotional abuse) or Family Crisis, or Other, provide additional information that would help us assess the need for care (i.e. severity, temporary or on-going) in the *Comments/detailed reason for referral* section.

***Child #2** (if applicable)*	**Full Name:**		**Date of Birth:**
Child's Address:			
Emergency-At-Risk*			**Comments / detailed reason for referral:**
Family Crisis*			
Cognitive Impairment			
Physical Limitations			
Communicative Needs			
Developmental Needs			
Other*			

***Child #3** (if applicable)*	**Full Name:**		**Date of Birth:**
Child's Address:			
Emergency-At-Risk*			**Comments / detailed reason for referral:**
Family Crisis*			
Cognitive Impairment			
Physical Limitations			
Communicative Needs			
Developmental Needs			
Other*			

Number of days approved for Child Care will be determined by Child Care & Early Years Division.

_______________________________ ***Referral Source Signature***

_______________________________ ***Date***

_______________________________ ***Case Manager Signature***

_______________________________ ***Date Received***