

3. Please document all support services currently involved with the child:

AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF INVOLVEMENT

4. List all support services that you have attempted to contact to obtain alternate funding/resources.

AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF CONTACT

5. List all of your attempts to secure volunteers to support your program.

AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF CONTACT

6. List current and future training that staff are participating in to support your program.

TYPE OF TRAINING	DATE OF TRAINING	NUMBER OF STAFF INVOLVED

**SECTION C
INDIVIDUAL CHILD INFORMATION**

Child's First Name: _____ Last Name: _____

Date of Birth : Day: _____ Month: _____ Year: _____

Confirmed Diagnosis (be specific): _____

Date Enrolled at Child Care Program: Day: _____ Month: _____ Year: _____

1. Age group/classroom that child is enrolled in. (If not placed in age appropriate group, please explain):

2. Does child attend JK/SK program outside of centre? Yes No

4. Total # of children in child care group/classroom _____ # of adults assigned to group _____

INDICATE CHILD'S HOURS EACH DAY AT CHILD CARE.

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Alt. Friday
Hours (I.e. 9 am - 3 p.m.)						

SAFETY

**SECTION D
PLAN / STRATEGIES**

Document the strategies to be used and the training plan to address the behaviours related to safety issues.

WHAT IS THE ISSUE/NEED? <small>(specify behaviour that results in a safety issue)</small>	WHAT STRATEGIES ARE YOU CURRENTLY USING?	WHAT PLANS DO YOU HAVE TO ADDRESS THE BEHAVIOURS?	DURING WHAT SPECIFIC TIMES OR ROUTINES IS SUPPORT REQUIRED?
<i>Examples:</i> -bites other children / staff -runs out of classroom & playground	-redirection -provide chewy tube -close doors and gates -visual supports (STOP signs)	-consultation visits with EI and OT to work out strategies -make all staff aware of situation and strategies	-free play time 9 to 10 a.m. -play time -outdoor time

MOBILITY

**SECTION D
PLAN / STRATEGIES**

Document the strategies to be used and the plan to address the special need(s) related to mobility issues.

<p>WHAT IS THE SPECIAL NEED? (that results in a mobility issue)</p>	<p>WHAT STRATEGIES ARE YOU CURRENTLY USING?</p>	<p>WHAT PLANS DO YOU HAVE TO ADDRESS THE CHILD'S NEED?</p>	<p>DURING WHAT SPECIFIC TIMES OR ROUTINES IS SUPPORT REQUIRED?</p>
<p><i>Examples:</i> -child is immobile; other children walk over child -child has visual impairment; a lot of stairs in program</p>	<p>-child is positioned in a safe area of the room -closely monitored -child's hand is held when using the stairs</p>	<p>-work with OT for strategies on activities to sit at the table, up on floor -looking at time of using stairs -more individual time to practise skill</p>	<p>-free play time -going in and out doors</p>

HEALTH

**SECTION D
PLAN / STRATEGIES**

Document the strategies to be used and the training plan to address the special need(s) related to health issues.

WHAT IS THE SPECIAL NEED? (that results in a health issue)	WHAT STRATEGIES ARE YOU CURRENTLY USING?	WHAT PLANS DO YOU HAVE TO ADDRESS THE CHILD'S NEED(S)?	WHAT SPECIFIC TIMES, ROUTINES OR SUPPORT ARE REQUIRED?
<i>Examples:</i> -choking at mealtimes -child has seizures	-child sits beside teacher -encouraged to take small bites of food -first aid training for staff, including management of seizures	-encouraged to eat a little bit at a time -OT consultation -ongoing training for new staff	-meal and snack times -ongoing

Additional information to support the application:

**SECTION E
ENHANCED FUNDING REQUEST**

Please check applicable funding period: January to June July to December

Funding start date: _____ Funding end date: _____

Total # of days for funding period (add # of days from start to end dates) _____

Total hours required per day: Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____

Is extra support required on PA days/during school breaks? Yes No

**SECTION F
SIGNATURES**

I hereby, apply for funding services and declare that the above information is true to the best of my knowledge. This application will be shared with:

- a) York Region, Community and Health Services Department, Family & Children's Services Branch
- b) The Child Care Enhancement Committee

_____ Parent/Guardian Signature	_____ Date
_____ Child Care Setting Supervisor Signature	_____ Date
_____ Consultant Signature (i.e. Early Interventionist)	_____ Date