

ENHANCED FUNDING GROUP APPLICATION

Is this the first time you have applied for Enhanced Funding for the children in this group application?
(Please check)

Yes (New Application)
 No (Re-Application)

SECTION A CHILD CARE SETTING INFORMATION

Program/Setting Name: _____ E-mail: _____
 Telephone: _____ Fax: _____
 Address: _____ City/Town: _____
 Mailing Address (if different from above): _____ Postal Code: _____
 Supervisor/Contact Person: _____
 Supporting Agency Contact Person: _____
(i.e. Early Intervention Services)
 Resource Teacher on-site: Yes No
 Program Type: Centred-Based Home-Based

SECTION B FUNDING CONDITIONS

To be eligible for funding, parent(s)/guardian(s) of the children in this group must require child care to support their employment and/or educational needs.

1. Please list all support services involved with the children:

CHILD'S NAME (first name, last initial)	AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF INVOLVEMENT

2. List all support services that you have attempted to contact to obtain alternate funding/resources, i.e. service clubs, special services at home, etc.

AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF CONTACT

3. List all of your attempts to secure volunteers to support your program, i.e. students, family members, etc.

AGENCY NAME	CONTACT PERSON	PHONE NUMBER	DATES OF CONTACT

4. List training that staff have or will be participating in to support the children with exceptional needs.

TYPE OF TRAINING	DATE OF TRAINING	NUMBER OF STAFF INVOLVED

**SECTION C
GROUP APPLICATION INFORMATION**

Age group/classroom that children are enrolled in. (If not placed in age appropriate group, explain why):

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

Child's Name (first name, last initial)	Date of Birth (day/month/year)	Confirmed Diagnosis, if known (be specific)	Indicate if Safety, Health or Mobility Issue

INDICATE EACH CHILD'S ATTENDANCE SCHEDULE AT CHILD CARE

Child's Name (first name, last initial)	Mon (times)	Tues (times)	Wed (times)	Thurs (times)	Fri. (times)	Alt. Fri (times)
<i>Example: Johnny S.</i>	<i>8-9 a.m. 3-5 p.m.</i>	<i>9 a.m. - 5 p.m.</i>	<i>8-9 a.m. 3-5 p.m.</i>	<i>9 a.m. - 5 p.m.</i>	<i>8-9 a.m. 3-5 p.m.</i>	<i>9 a.m. - 5 p.m.</i>

SAFETY

**SECTION D
PLAN / STRATEGIES**

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

CHILD'S NAME (first name, last initial)	WHAT IS THE ISSUE / NEED? (specify behaviour that results in a safety issue)	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: Johnny S.</i>	<i>-bites other children / staff</i>	<i>-redirection -provide chewy tube</i>	<i>-consultation visits with EI and OT to work out strategies</i>	<i>-free play time 9 to 10 a.m.</i>
<i>Susie J.</i>	<i>-runs out of classroom & playground</i>	<i>-close doors and gates -visual supports (STOP signs)</i>	<i>-make all staff aware of situation and strategies</i>	<i>-play time -outdoor time</i>

MOBILITY	PLAN / STRATEGIES
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Document the strategies to be used and the training plan to address the special needs related to mobility issues.

CHILD'S NAME (first name, last initial)	WHAT IS THE SPECIAL NEED? (that results in a mobility issue)	WHAT STRATEGIES ARE YOU CURRENTLY USING?	WHAT PLANS DO YOU HAVE TO ADDRESS THE CHILD'S NEED?	DURING WHAT SPECIFIC TIMES OR ROUTINES IS SUPPORT REQUIRED?
<i>Examples:</i> -Tommy J. -Suzy W.	-child is immobile; other children walk over child -child has visual impairment; a lot of stairs in program	-child positioned in safe area of the room -closely monitored -child's hand is held when using the stairs	-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 do on her own	-free play time -going in and out doors

HEALTH**PLAN / STRATEGIES**

Document the strategies to be used and the training plan to address the special needs related to health issues.

CHILD'S NAME (first name, last initial)	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 CHILDREN'S NEEDS?	DURING WHAT SPECIFIC TIMES OR ROUTINES IS SUPPORT REQUIRED?
<i>Examples: -Billy T. -Jenny B.</i>	<i>-choking at mealtimes -child has seizures</i>	<i>-child sits beside teacher -encouraged to take small bites of food -staff training in first aid, including seizure management</i>	<i>-encouraged to eat a little bit at a time -OT consultation -meet with parents and EIS staff to go through procedure</i>	<i>-meal and snack times -ongoing</i>

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 the above information to be true. To the best of my knowledge, the parents of the children identified within this group application are engaged in an approved activity (employment/education/training), and the funding request is consistent with the parent's attendance at work/school.

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

Child Care Setting Supervisor Signature Date

Consultant Signature (i.e. Early Interventionist) Date