

IMPORTANT NOTE TO THE PHYSICIAN OR REFERRING AGENCY

This form is to be completed by a health or social services professional currently working with this family. By stating "yes" to any of the questions below, you feel that the child's development or safety may be at risk without the benefit of a licensed child care setting.

SECTION 1: EXCEPTIONAL CIRCUMSTANCES AND CHILD CARE REQUIREMENTS

Must be completed by referring physician/agency/organization.

Name of client

1. Does the parent/guardian have a substantial health impairment that is continuous or recurrent and preventing them from adequately caring for their child(ren)? For example: limited mobility, stamina, physical limitations such as lifting their child(ren) or a mental health concern Yes No

Name of child(ren)

2. Does the child(ren) have a special need that may be emotional, physical, sensory, communication, developmental or behavioural? Yes No
3. Is the child(ren)'s health, welfare and safety at risk? Yes No
4. Is the referring physician/agency recommending child care due to the fact that the child's development or safety could be at risk without child care? Yes No
- If yes, indicate level of need: Beneficial e.g. socialization/parent respite
High Risk e.g. safety is a concern, child could be at immediate risk

5. Child care is required for: Less than six months (months required:)
Six months
More than six months (the child has a lifelong diagnosis)

6. Please indicate the number of days per week child care is required:

7. Amount of child care required: Full Days Part Days

Date: (mm/dd/yy)

SECTION 2 – PHYSICIAN / AGENCY / ORGANIZATION INFORMATION

Physician/agency/organization representative's signature Date (mm/dd/yy)

Name of referring physician/agency/organization representative completing this form



CHILD CARE FEE SUBSIDY

Verification for Need for Child Care Special Needs, Significant Risk or Exceptional Circumstances

Address

Street number Street name
Unit number City/Town
Province Postal code
Phone number

The information provided will be used to determine eligibility for families where there is a special need or exceptional circumstance which may be given consideration in the fee subsidy application process. Please note that income-based testing is the first factor in determining financial eligibility.

SECTION 3 – CONSENT FOR RELEASE OF INFORMATION

Must be completed by client requesting Child Care Fee Subsidy

Client name

Phone number

I, the undersigned, hereby authorize The Regional Municipality of York, Community and Health Services Department, Child Care Services, to obtain any verbal or written information from:

(referring physician/agency/organization)

for the purpose of verifying my eligibility for Child Care Fee Subsidy. I understand that such information is confidentially retained in my file.

Client signature

Date (mm/dd/yy)

This form should be returned to The Regional Municipality of York:

50 High Tech Road, 4th Floor, Richmond Hill, ON L4B 4N7

Fax: 905-762-2099

17310 Yonge Street, Unit 9, Newmarket, ON L3Y 7R8

Fax: 905-895-8377

9060 Jane Street, Vaughan, ON L4K 0G5

Fax: 905-660-4865

24262 Woodbine Avenue | Keswick, ON L4P 3E9

Fax: 905-895-8377

9275 Markham Road, Unit 15, Markham, ON L6E 1A2

Fax: 905-762-2099

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.)

Personal Information in this Consent is collected under the legal authority of the Child Care and Early Years Act, 2014, for the purpose of verifying eligibility or continuing eligibility for Child Care Fee Subsidy. For more information, contact the Manager of Child Care Services, The Regional Municipality of York, 520 Cane Parkway, Newmarket, ON L3Y 8T5, telephone: 1-877-464-9675 ext. 76655.

If you have questions about your Child Care Fee Subsidy, please contact your Children's Services Representative or call Access York at 1-877-464-9675.