CHILD CARE FEE SUBSIDY
Verification for Need for Child Care Special Needs, Significant Risk or Exceptional Circumstances

SECTION 1 – CONSENT FOR RELEASE OF INFORMATION

To be completed by applicant requesting Child Care Fee Subsidy

Applicant 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.

Applicant signature

Date (mm/dd/yy)

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 household. 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. Financial eligibility is the first factor using income-based testing.

SECTION 2 – EXCEPTIONAL CIRCUMSTANCES AND CHILD CARE REQUIREMENTS

To be completed by referring physician/agency/organization

Applicant name

1. Does parent/guardian have a substantial physical or mental 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)

   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 immediate and/or grave risk? Yes ☐ No ☐

4. Is the referring physician/agency/organization recommending child care based on the above information? Yes ☐ No ☐

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Select the amount of child care that would be most appropriate to address the needs of this family.

Number of months care required:

(update will be required if care is to continue for period longer than six months)

From: to:

Number of days per week care required (indicate 1-5 days):

Please indicate amount of care needed (check one): ☐ Full Days ☐ Part Days

SECTION 3 – REFERRING PHYSICIAN/AGENCY/ORGANIZATION INFORMATION

Physician/agency/organization representative's signature

Date (mm/dd/yy)

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

Address

Street number Street name

Unit number City/Town

Province Postal code

Phone number

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 or

17310 Yonge Street, Unit 9, Newmarket, ON L3Y 7R8
Fax: 905-895-8377 or

9060 Jane Street, Vaughan, ON L4K 0G5
Fax: 905-660-4865

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 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.