District of Parry Sound Social Services Administration Board

☐ **Initial Referral**

☐ **Follow-up Referral**

PROFESSIONAL REFERRAL FOR CHILD CARE FEE SUBSIDY

THIS FORM IS TO BE COMPLETED BY A HEALTH OR SOCIAL SERVICES PROFESSIONAL

THE INFORMATION PROVIDED WILL BE USED TO DETERMINE ELIGIBILITY FOR CHILD CARE FEE SUBSIDY

Ensure all sections are completed, submit this form to the Child Care Service Management department for review.

Email: subsidy@psdssab.org or Fax: 705-746-8731

DATE: _____

PLEASE CHECK THE BOXES THAT APPLY:

☐ **Child Focused Referral**

- ☐ Child has a diagnosed special need; medical condition or additional care needs are required Parent(s)/Guardian(s) working or attending school;
- ☐ Child has a diagnosed special need; medical condition or additional care needs are required Parent(s)/Guardian(s) not working or attending school

☐ **Parent/Guardian Focused Referral**

- ☐ Parent/Guardian has a diagnosed special need; medical condition or additional care needs are required Parent(s)/Guardian(s) working or attending school;
- ☐ Parent/Guardian has a diagnosed special need; medical condition or additional care needs are required Parent(s)/Guardian(s) not working or attending school

FAMILY INFORMATION

Parent(s)/Guardian(s) Full Name:	Home Address:	Telephone Number:

Child(ren) Requiring Care (Full Name)	Date of Birth:

When will family require child care:	
Start Date: _____ ☐ Full Days ☐ Before School ☐ After School	End Date/Duration: _____ ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other
Recommended number of days per week: _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	

Please identify how placement in an early learning and child care setting will help meet the needs of the child(ren)/family?	
Child Focused (check all that apply): ☐ Cognitive ☐ Language ☐ Gross Motor ☐ Fine Motor ☐ Social/Emotional ☐ Self-Help ☐ Socialization ☐ Maintaining routine ☐ Other (Please explain) _____	Parent Focused (check all that apply): ☐ Respite (i.e. mental health) ☐ Medical challenges/recovery ☐ Treatment/therapy ☐ Other (please explain): _____

Please Note: Application must be updated annually or when a change in circumstance occurs

_____ _____
Referring Agency/Service/Professional Telephone Number

_____ _____
Name of Referrer (please print) Relationship to Applicant

_____ _____
Referrer Signature Date

Updated October, 2022