District of Parry Sound Social Services Administration Board

CHILDREN'S SERVICES SAP INTAKE FORM

Appendix-C1-SAP

IMPORTANT - Complete, save and email this form to sap@psdssab.org. This form is NOT automatically submitted.

Parent/Legal Guardian Contact Information: Contacted by: Phone ☐ In Person ☐ Email ☐

Date:	Requested Date of Care:	Current Age of Child:
Applicant's Legal Name:	Applicant's Common Name:	
Home #:	Cell #:	Best # to reach you: Home: ☐ Cell: ☐
Email Address:	Mailing Address:	
Work Place:	Educational Program:	
OW/ODSP: ☐	Single Parent: ☐	Two Parents: ☐
Referral (special needs): ☐	Socialization: ☐	
Is there a formal parental agreement in place? Yes ☐ No ☐ Not Applicable ☐ *If yes, please provide a copy.*		

Child's Information:

Name:	Date of Birth:	
Care Required: Before School ☐ After School ☐ Full Day Program ☐		
Requested Program: _____		
Requested Days & Hours of Care: _____to _____	Mon: ☐ Tues: ☐ Wed: ☐ Thurs: ☐ Fri: ☐	
Scheduled Care: ☐ Schedule received?: Weekly: ☐ Bi-Weekly: ☐ Monthly: ☐ Other: ☐ If other, please explain: _____		
Are there any concerns with allergies or any other considerations? Yes ☐ No ☐ If yes, please explain: _____		

Is your child connected to any of the following supports?

- ☐ Speech/Language
- ☐ Occupational/Physical Therapy
- ☐ Behavioural Therapy (including behavioural plan)
- ☐ Children's Aid Society (CAS)
- ☐ Inclusion Support Services (ISS)
- ☐ Other: _____

Sibling Information:

Name:			Date of Birth:		
Program: Infant ☐	Toddler ☐	Preschool ☐	Before School ☐	After School ☐	
Name:			Date of Birth:		
Program: Infant ☐	Toddler ☐	Preschool ☐	Before School ☐	After School ☐	

Referral Information:

Child Care Fee Subsidy: 705-746-7777 ext. 5277 Referred: Yes ☐ No ☐
Referred to another child care program: Yes ☐ No ☐ Shared intake with: HCCP ☐ ELCCC ☐_____

Notes:

(Revised July 2021)