

### 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 completing this form and stating yes to the questions below you acknowledge that the child's development or safety may be at risk without the benefit of a licensed child care setting. Referrals for school age children should only be made when there are extenuating circumstances and you believe the child will be at risk without before/ after school child care.

CHILD CARE FEE SUBSIDY IS INTENDED TO SUPPORT A CLIENT'S ABILITY TO WORK OR ATTEND SCHOOL AND IS A LIMITED TAX BASED RESOURCE.

Referring agency initials required

### SECTION 1: EXCEPTIONAL CIRCUMSTANCES AND CHILD CARE REQUIREMENTS

Must be completed by referring physician/agency/organization.

Name of Parent/Guardian

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. Is the condition recurrent or ongoing?    Yes    No

6. Child care is required for:    Less than six months (months required:    )

Six months (extension of referral required after six months)

More than six months (extension of referral required annually)

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

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

9. (Only complete for school age children) Is there an extenuating circumstance where the need for socialization for child or respite for parent is not met during the school day?    Yes    No

Effective 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

**Physician/Agency/Organization 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)



# CHILD CARE FEE SUBSIDY

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

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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

17150 Yonge Street, Unit 6, Newmarket, ON L3Y 8V3

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 for the purpose of verifying eligibility or continuing eligibility for Child Care Fee Assistance. For more information contact the Manager of Child Care Services, The Regional Municipality of York, 17150 Yonge Street, Newmarket, Ontario, L3Y 8V3 Tel: 1877 -464-9675 Ext 76655