

Child Care Referral Form

Once this form has been completed and signed, please email or drop off the form to the Child Care and Early Years office (info at the top).

If you require assistance completing this form, please refer to our guide:
<https://www.chatham-kent.ca/community/childcare/Pages/Special-Needs-Services.aspx>

Parent/Guardian Information (please print):

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Referring Agency / Health Care Professional (please print):

Contact Name: _____

Referring Agency: _____

Title/Position: _____ Phone Number: _____

Email Address: _____

Address: _____

Consent:

I verify that I have obtained a consent form from the parent/guardian which allows our agency/office to share the information on this form for the purpose of determining eligibility for child care fee subsidy.

Referring Source Signature: _____ Date: _____

**Our organization understands the importance and benefits of child care for children and families.
Most children benefit from a structured day, routine, and socialization.**

**However, for the purpose of this referral please provide supporting detail specific to the need for
child care.**

Please note: only children that have secured a child care spot would be considered for subsidy.

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)

This information is collected under the legal authority of the Child Care and Early Years Act 2014, s.71 or the Ministry of Community and Social Services Act, for the purpose of administering Government of Ontario social assistance programs and/or Municipality of Chatham-Kent social programs.

Referral Details (please print):
Service Length: 1-3 months 3-6 months 6-12months Indefinitely

***A referral can only be granted for as long as you are working with the child/family but not more than 12 months. Typically, referrals are for **2 full days or 4 half days** of child care per week.

Reason for Referral:
 Parent's needs (Parent's name: _____ Date of Birth: _____)

 Child's needs (Child's name: _____ Date of Birth: _____)

Reason	Yes/No	Comment / Reasoning (required)
Physical Limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Medical Need	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Cognitive Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Communicative Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Developmental Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Emergency-at-risk / Family Crisis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected	

Contact from a Case Manager is needed to discuss this referral further.

I certify that the above information is correct to the best of my knowledge. I acknowledge I will contact the Municipality of Chatham-Kent if the Parent/Guardian's file with the agency has closed.

Referring Source Signature: _____ Date: _____