☐ **Initial Referral**

☐ **Follow-up Referral**

District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

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.

Please ensure that all sections are completed – Thank you.

DATE: ______________________________

PLEASE CHECK THE BOX THAT APPLIES:

Form Completed by:

☐ OKP ☐ HANDS ☐ CAS

☐ Multicultural Centre ☐ Community Living North Bay ☐ Stepping Stones

☐ Family Physician ☐ Nurse Practitioner ☐ Other

If other, please list the agency and your Position (please note that this will have to be reviewed before approving): ____

IS THE REFERRAL FOR CHILD OR PARENT?
Check either Child or Parent and complete corresponding sections.

☐ **CHILD FOCUSED REFERRAL**:

1. Does the child have a <u>diagnosed</u> special need, medical condition? ☐ No ☐ Yes
   - Is the child participating in a service (s) listed above? ☐ No ☐ Yes
   - Is the child on a waiting list for any services listed above? ☐ No ☐ Yes
   - Is the child involved with the Inclusion Support Program (support services provided in the child care centre)? ☐ No ☐ Yes
2. Does the child require support not related to medical or special needs (e.g. Referrals from CAS, physicians, Multicultural Society, other)? ☐ No ☐ Yes
   - What is the reason or need for care? Please check off all that apply.

☐ Physical development ☐ Communication ☐ Language

☐ Change in family dynamics ☐ New to Canada ☐ Cultural Support

☐ Building peer relationships ☐ Other (e.g. School readiness)

- If you checked “other”, a detailed explanation is required in order for DNSSAB to review:

____

- How will placement in an early learning and child care centre meet the needs of the child(ren)?

____

PARENT FOCUSED REFERRAL (e.g. CAS; from family doctor, etc.)

1. Does the parent have a <u>diagnosed</u> special need or medical condition? ☐ No ☐ Yes
2. Does the parent require support not related to medical or special needs (e.g. CAS, Community Counselling Centre, Multicultural Centre, etc.)? ☐ No ☐ Yes

➢ Details of parent’s diagnosis or medical condition not required.

APPLICACANT **INFORMATION**

Parent(s) Guardian(s) Full Name:	Home Adress:	Telephone Number:

Child(ren) requiring care for this referral:

Child’s Full Name:	Date of Birth:

*****This form must be completed and signed by referring agent.*****

When will family require child care:	
Start Date: ☐ Full Days (6 hours of more) ☐ Half Days (less than 6 hours) ☐ PD days/Breaks ☐ Before School ☐ After School	End Date/Duration: ______________ ☐ 3 months ☐ 6 months ☐ 12 months ___________ weeks
Recommended number of days per week: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri	Recommended Hours of Care: _________

**PLEASE NOTE:

- The referral will be reviewed and approved based on content and completeness of information provided. Lack of information or sections not completed may deem the referral to be denied or delayed.
- The referral must be completed by a third-party professional or agency. To avoid potential conflicts, the individual signing the referral should not be related to the child(ren) or parent.
- If the referring professional/agency no longer provides support to the child(ren) or parent, please notify the Child Care Fee Subsidy office (contact information is provided below).
- SIGNED REFERRALS REQUIRED AT LEASET ANNUALLY. If support is required beyond the recommended duration, number of days per week or recommended hours of care, an updated referral form is required.
- DNSSAB is not responsible for fees associated with obtaining any referral.

Referring Agency/Service/Professional	Telephone Number
Name of Referrer (please print)	Relationship to Applicant
Referrer Signature	Date

CONTACTING DNSSAB:

INQUIRIES: 705-474-2151 ext.**15558**

SUBMITTING DOCUMENTS: Email CSR directly: Please choose
Or if CSR is unknown, please email childrenservices@dnssab.ca

Fax to: Attention: CHILDREN'S SERVICES

Mail to: DNSSAB/CHILDREN'S SERVICES

200 McIntyre St E., P.O. BOX 750 **North Bay**, ON P1B 8J8	94 King St., Unit 15 **Sturgeon Falls**, ON P2B 2Z5	540 Valois Dr. **Mattawa**, ON P0H 1V0

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 Family Benefits Act, R.S.O. 1990, C.F.2, sections 9 & 12, the Ontario Disability Support Program Act, 1997, sections 5 & 10, or the Ontario Works Act, 1997, sections 7, 8, & 15, for the purpose of administering Government of Ontario social assistance programs.