



THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

SOCIAL / SPECIAL NEEDS REFERRAL CHILD CARE FEE SUBSIDY APPLICATION

Send or Fax to:

TBDSSAB Children's Services Division
231 May Street South, Thunder Bay, ON P7E 1B5
Phone: 807 - 766-2111 Fax: 807 - 345-9412

*This form is to be completed by a **health or social services professional** currently working with this household. The information provided will be used to determine eligibility for fee subsidy for families who are not currently working or attending school.*

Please Check One or Both:

Date: _____

- Social Referral - fee subsidy requested and family not working or going to school
- Special Needs Referral - child has a diagnosed special need or additional care needs, and the family / referring agency requires assistance in finding a child care space

Applicant Information

Parent/Guardian(s) Full Name(s) 1)	Address	Phone Number(s)
2)		
Full Name of Child	Date of Birth (M/D/Y)	
Full Name of Child	Date of Birth (M/D/Y)	
Full Name of Child	Date of Birth (M/D/Y)	

Preferred Child Care Centre(s)

- 1) Name of Centre: Space Secured Space is available On waitlist
- 2) Name of Centre: Space Secured Space is available On waitlist
- 3) Name of Centre: Space Secured Space is available On waitlist
- No preference

Comments:

- | | | |
|---|----------|---|
| <input type="checkbox"/> Child Focused Service Assessment (if applicable) | AND / OR | <input type="checkbox"/> Parent Focused Service Assessment (if applicable) |
| <input type="checkbox"/> Yes, is available <input type="checkbox"/> No, in progress | | <input type="checkbox"/> in agency file <input type="checkbox"/> medical <input type="checkbox"/> other _____ |

When will family require child care:

Start Date:

End Date:

- Full Days Half Days
 Mon Tues Wed Thurs Fri

Is/Are the parent(s)/caregiver(s) able to work/attend school outside the home on a full-time basis, assuming that child care needs are met? Please explain.

What factors prevent the parent(s)/caregivers(s) from providing adequate daily care for the child?



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Based on your knowledge of the family, please indicate the risk factors that the child is experiencing which warrants a referral for care? (check all applicable risk factors and circle the level of concern)

Environmental	Biological	Psycho-social	Familial
<ul style="list-style-type: none"> <input type="checkbox"/> Lack of stable housing <input type="checkbox"/> Impoverished social environment <input type="checkbox"/> Social isolation <input type="checkbox"/> Poverty <input type="checkbox"/> Non-English or limited English speaking home <input type="checkbox"/> Housing in rural or isolated area 	<ul style="list-style-type: none"> <input type="checkbox"/> Premature birth <input type="checkbox"/> Low birth weight <input type="checkbox"/> Nutritionally deficient <input type="checkbox"/> Long term or chronic illness <input type="checkbox"/> Formally diagnosed developmental condition 	<ul style="list-style-type: none"> <input type="checkbox"/> Developmentally immature <input type="checkbox"/> Physical and/or sexual abuse or neglect <input type="checkbox"/> Destructive or violent temperament <input type="checkbox"/> Language deficiency <input type="checkbox"/> Significant loss(es) <input type="checkbox"/> Failed attachment to primary caregiver <input type="checkbox"/> Difficult disposition or temperament <input type="checkbox"/> Challenging behaviour 	<ul style="list-style-type: none"> <input type="checkbox"/> Parental substance abuse or addiction <input type="checkbox"/> Family history of poor academic achievement <input type="checkbox"/> History of diagnosed family problems <input type="checkbox"/> Family history of criminal involvement <input type="checkbox"/> Parental illiteracy <input type="checkbox"/> Parent unemployment <input type="checkbox"/> Low family income <input type="checkbox"/> Teenage parenthood <input type="checkbox"/> Chronic illness in family <input type="checkbox"/> Single parent
Overall level of concern: High Moderate Low	Overall level of concern: High Moderate Low	Overall level of concern: High Moderate Low	Overall level of concern: High Moderate Low

How will placement in a child care centre meet these particular needs?

If the child attends school, describe the need for child care before/after school.

What are the specific needs of this child? (Please attach available medical/third-party assessments and indicate other services the parent(s)/caregiver(s) is/are currently accessing.)

<input type="checkbox"/> George Jeffrey Children's Centre	<input type="checkbox"/> Children's Centre Thunder Bay
<input type="checkbox"/> Health Unit: <input type="checkbox"/> Preschool Communication Services	<input type="checkbox"/> Children's Aid Society
<input type="checkbox"/> Healthy Babies / Healthy Children	<input type="checkbox"/> Dilico
<input type="checkbox"/> Fair Start	<input type="checkbox"/> Wesway



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Please indicate which community resources you have explored for this family.

Describe your plan for continued involvement/case management with this family.

Name of Referring Agency

Contact Phone Number

Fax

Contact Name (Please Print)

Contact Signature

Date

CONSENT TO RELEASE and/or COLLECT INFORMATION (To be Completed by Parent/Guardian)

I/We consent to the collection, use and disclosure of personal information relevant to the above-named child, to and/or from child care programs, home child care providers, referring agencies, The District of Thunder Bay Social Services Children's Services Division, and Ministries that provide funding / resources / services.

I / we _____
Name of Parent(s)/Guardian(s)

in accordance with *Section 31 (a) and 31 (b)* of the *Municipal Freedom of Information and Protection of Privacy Act*,

hereby authorize and direct _____ to release
Name of Agency

to The District of Thunder Bay Social Services Administration Board, Children's Services, the information requested.

The following agencies or persons are not to be included:

Signature of Parent/Guardian

Relationship to Child

Date

Signature of Parent/Guardian

Relationship to Child

Date



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CHILD DEVELOPMENT PROFILE (Only required for Special Needs Referrals)

Name of Child _____

Please complete this section so that we can best meet the needs of your child.

What is your child's diagnosed special need or additional care needs?
Please specify:

Assessments completed, if applicable:

1)

2)

Has your child participated in Fair Start Screening?

Yes Date: No

Does your child receive regular administered medication? Yes No
If yes, please specify:

Self Help:

Toileting Independent With Assistance Dependent

Dressing Independent With Assistance Dependent

Feeding Independent With Assistance Dependent

Motor Skills:

Crawling Yes With Assistance No

Walking Yes With Assistance No

Adaptive Equipment – Specify:

How does your child communicate?

Every child is different and every day is different. Tell us about how your child behaves most days.

Provide any other information that may be helpful for us to know about your child.

A Special Needs Child is defined as one who has a physical or mental impairment that is likely to continue for a prolonged period of time and who as a result thereof is limited in activities pertaining to normal living as verified by objective psychological or medical findings and includes a child with a developmental disability (a condition of mental impairment present or occurring during a person's formative years, that is associated with limitations in adaptive behaviour).