



*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.*

**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.

**Updates:** Updates to the Social/Special Needs Referral are required yearly unless it is a child diagnosed with Special Needs. Special Needs referrals do not require updates.

**Application needs to be completed in full to be considered for approval**

**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)	

Has family secured a space at a Child Care Centre?  Yes  No

1) Name of Centre:

If family has not secured a space, please direct family to go to [www.thunderbaychildcare.ca](http://www.thunderbaychildcare.ca) to place their name on the waitlist for the Centre(s) of their choice.

When will family require child care: Start Date:                      End Date:	<input type="checkbox"/> Full Days <input type="checkbox"/> Half Days <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri
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**Does the child have a diagnosed Special Need?** (ex. Autism, Cerebral Palsy, ADHD, Down Syndrome, etc.)

Yes  No **If yes, please attach a copy of the assessment.**

Please specify:

**Reason for Referral:** What are the child/family circumstances and how will placement in a Child Care Centre assist the parent and/or child?

**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).

**Treatment Plan:** What services, treatment, and resources is the parent/child currently receiving?

**Enhanced Program Support:** Will this child require enhanced program support (individualized support) to attend the child care program?

**Continuum of Care Plan:** Describe your plan for continued involvement/case management with this family.

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

<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	<input type="checkbox"/> Other _____

_____ 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 \_\_\_\_\_  
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

**Please forward ALL referrals to the Central Intake Fax at:  
(807) 345-7921  
For child care programs in:  
Geraldton, Longlac, Manitouwadge, Marathon, Nakina, Nipigon,  
Schreiber, Terrace Bay, Thunder Bay**