PART A: TO BE COMPLETED BY THE INDIVIDUALS REQUIRING CHILD CARE (OR A REPRESENTATIVE)

Instructions: Step 1: Complete Part A and the Consent to Share Information with family.
Step 2: Practitioners/Professionals complete Part B.
Step 3: Fax completed application to Therapeutic Coordinators, City of Hamilton, at fax number below.

Therapeutic Program Coordinators, Children's & Community Services,
City of Hamilton Lister Block Building, 6th Floor, City Hall, 71 Main Street West P.O. BOX 2040 Hamilton, Ontario, Canada L8P 4Y5

FAX TO: 905.546.4668

When reviewing the application, we may contact the applicant, the qualified practitioner/professional or children's aid agency (named on this application or any attached document) who knows about your situation, if we need more information to complete the application process.

PART A: INFORMATION ABOUT THE PARENT(S)/GUARDIAN(S)
(only include parent(s) who live in home with child – include common-law partners as parents)

Applicant 1		**Applicant 2**	
Last Name	First Name	Last Name	First Name
Date of Birth (dd/mm/yyyy)		Date of Birth (dd/mm/yyyy)	
Gender Identity		Gender Identity	
Relationship to Child		Relationship to Child	
Language Spoken		Language Spoken	
Phone	Alternate Phone	Phone	Alternate Phone

Email

Home Address — Street # | Street Name | Apartment/Unit # | City | Postal Code

Mailing Address **(if different)**

Marital Status ☐ Single ☐ Separated ☐ Divorced ☐ Common-Law ☐ Married ☐ Widowed

PART A: INFOR MATION ABOUT ALL CHILDREN IN THE HOUSEHOLD

Child Care Required	Last Name	First Name	Date of Birth (dd/mm/yyyy)	Gender Identity
☐				
☐				
☐				
☐				
☐				
☐				
☐				

Does the family want to apply for Child Care Fee Subsidy (financial assistance)? ☐ Yes ☐ No
(if yes, complete the householdincome section)

PART A: INFORMATION ABOUT HOUSEHOLD INCOME

My source of income is: ☐ Ontario Works (OW) ☐ Ontario Disability Support Program (ODSP) ☐ Other

GO TO PART B TO COMPLETE FORM

PART B: TO BE COMPLETED BY THE QUALIFIED PRACTITIONER/PROFESSIONAL

Instructions: Complete only the sections in Part B that apply to your client or patient.

If the reason for the referral is:

1) related to the child's condition, who needs child care: Complete section 1 & 3
2) related to the parent(s)' condition: Complete section 2 & 3
3) related to a sibling(s)' condition: GO directly to section 3 and provide details

PART B - SECTION 1: INFORMATION ABOUT CHILD

☐ Not applicable

Last Name	First Name	Date of Birth (dd/mm/yyyy)	Gender Identity

PART B – SECTION 1: INFORMATION ABOUT CHILD CARE

Is the child in a licensed child care? **(if yes, provide child care provider name)** ☐ Yes ☐ No

Child care provider name

Date of most recent visit with child (D/M/Y) _____ Type of referral ☐ New ☐ Update

PART B – SECTION 1: INDICATE CONCERNS THAT APPLY TO CHILD

☐ Expressive or ☐ Receptive Speech/Language Delays
☐ Communication Concerns ☐ Mental Health ☐ Physical & Motor Development
☐ Developmental Delays ☐ Special Needs Diagnosis ☐ Victim or Witness of Abuse
☐ Emotional/Social (behaviour, unusual interactions, etc.)

Please provide a detailed explanation about the concerns for this child and family and indicate other professional services referred to or involved with this child and family.

CONTINUE COMPLETING PART B

PART B (CONT'D): TO BE COMPLETED BY THE QUALIFIED PRACTITIONER/PROFESSIONAL

PART B – SECTION 2: INFORMATION ABOUT PARENT ☐ **Not applicable**

Last Name	First Name	Date of Birth (dd/mm/yyyy)	Gender Identity

Date of most recent visit with parent (D/M/Y) _____ Type of referral ☐ New ☐ Update

PART B – SECTION 2: INDICATE CONCERN(S) AND/OR TREATMENT(S) THAT APPLY TO THE PARENT

☐ Cognitive ☐ Hearing Impaired ☐ Visually Impaired ☐ Physical Limitations in Caring for Child

☐ Medications that Impair Mental Functioning ☐ Mental Health Treatment ☐ Physical Injury Treatment ☐ Other Condition(s) or Treatment(s)

Please provide a detailed explanation of the parent's concern(s) and/or treatment(s)

PART B – SECTION 2: HOW LONG CONCERN(S) AND/OR TREATMENT IS EXPECTED TO LAST

☐ Permanent/Ongoing	☐ Temporary	Expected Length of Condition	# of Times per Week for Treatment

In a two parent household the OTHER parent is unable to care for the child(ren) because

☐ Work at least 20 hours/week ☐ Attending School Full Time ☐ Other **(use section 3 to explain)**

PART B – SECTION 3: ADDITIONAL COMMENTS/CONCERNS

CONTINUE COMPLETING PART B

PART B (CONT'D): TO BE COMPLETED BY THE QUALIFIED PRACTITIONER/PROFESSIONAL

PART B: INFORMATION ABOUT REFERRAL AGENT

What is the anticipated length of time that you will be involved with this child/family?

☐ Short Term ☐ Ongoing ☐ I will be the ongoing referring agent ☐ I will **NOT** be the ongoing referral agent **(explain below)**

Please indicate other professional(s)/service(s) that will be the ongoing referral agent

PART B: INFORMATION ABOUT REFERRAL AGENT QUALIFICATIONS
(If further information is needed, the City of Hamilton, Children's Services may contact you)

Check the box that applies to you:

☐ Medical Doctor ☐ Psychologist ☐ Speech-Language Pathologist
☐ Children's Aid Worker ☐ Resource Consultant ☐ Other: **(please specify)**

As a qualified professional, I certify that to the best of my knowledge the information given in Part B of this form is correct and complete and I understand that this information will be used by the City of Hamilton to determine if my patient or client qualifies for services.

SIGN HERE:

Print Name	Agency
Address	
Date	Phone	Fax

The family must meet financial eligibility criteria which will be determined by the City of Hamilton, Child Care Subsidy office, even if approval has been granted.

The parents/guardian must sign the attached Consent to Share Information in order for this information to be forwarded to the Special Needs Resourcing agency for support.

GO TO CONSENT TO SHARE INFORMATION TO COMPLETE THE APPLICATION WITH FAMILY

FOR INTERNAL USE ONLY

☐ Approval Date (d/m/y) _____ ☐ Yes ☐ No Sent to Community Living Hamilton (d/m/y) _____

Notes

Consent to Share Information Form

1. The "Special Needs Resourcing" program involves the following organizations (collectively called "the Agencies") working together to ensure families with children who have special needs can receive "Special Needs Resourcing" to ensure full inclusion of your child in licensed child care services:
   - Therapeutic Program Coordinators, Children's & Community Services Division , City of Hamilton
   - Early Childhood Resource Consultant, Community Living Hamilton
   - Early Childhood Resource Teachers, Red Hill Family Centre, City of Hamilton
   - Ron Joyce Children's Health Centre
   - Supervisors, Licensed Child Care
   - Children's Aid Worker, Children's Aid Society and Catholic Children's Aid Society
   - Qualified Practitioner/Professional: Medical Doctor, Psychologist, & Speech-Language Pathologist
   - Other as described: _____

2. In order to provide your child with the special needs resources available through the "Special Needs Resourcing" program, we need to collect, use and disclose personal information and/or personal health information about you and your child shared with us for the purposes of the "Special Needs Resourcing".

3. Information collected will be used for the following purposes:
   a. to determine eligibility for "Special Needs Resourcing" and child care fee subsidy;
   b. to support parents/caregivers with licensed child care placement;
   c. as appropriate, to refer your child to agencies associated with the "Special Needs Resourcing" program for provision of licensed child care services;
   d. to administer and operate the "Special Needs Resourcing" program; and
   e. to assist the City of Hamilton, Children's & Community Services Division and the "Special Needs Resourcing" program with planning, monitoring, reporting, evaluation, research and accountability to the Ministry of Education.

The collection, use and disclosure of personal information and/or personal health information will be limited to what is reasonably necessary to meet the purpose of the collection or use.

4. Any personal information and/or personal health information collected will be kept confidential and will be used and disclosed only during the time in which you or your child is participating in the "Special Needs Resourcing" program, or upon the request of the custodial parent/legal guardian or as otherwise permitted or required by law.

I, _____ , hereby consent to
Name of Custodial Parent/Legal Guardian (please print)

the "Special Needs Resourcing" program and each of the Agencies collecting, using and disclosing personal information and/or personal health information about me and my child, as identified in this application, to the extent that information is needed to carry out the purposes listed in paragraph 3.

I also hereby consent to the exchange of personal information and/or personal health information about me and my child between the "Special Needs Resourcing" program and each of the Agencies to the extent that the information is needed to carry out the purposes listed above in paragraph 3. I understand that speaking with staff from the Agencies will not always results in "Special Needs Resourcing" for licensed child care.

I hereby state that I have read and understand the contents of this consent form. I declare that this consent has been given voluntarily. I understand that this consent shall remain in force and effect until the end of my and my child's involvement in the Special Needs Resourcing program and its related services.

I understand that I may change or withdraw my consent at any time by giving the "Special Needs Resourcing" program notice in writing. However, I also understand that, if I change or withdraw my consent, it will limit the range of services available to assist my child in child care.

_____ _____
Signature of Custodial Parent/Legal Guardian Date (Day/Month/Year)
(Provide Copy to Parent)

This information is collected under the legal authority of *s. 5* of the *Health Protection and Promotion Act* and *s. 227* of the *Municipal Act, 2001* and *Child Care and Early Years Act, 2014, S.O. 2014, c. 11, Sched. 1, section 71,* The information will be used for the purpose of administering the "Special Needs Resourcing" program, including for the purposes of determining eligibility for services, pro gram evaluation and statistical use. For more information, contact [Therapeutic Program Coordinator] Children's Services and Neighbourhood Development Division, Healthy and Safe Communities Department, at 905.546.2424 ext. 4872 or 4186.