REFERRAL FOR MEDICAL AND/OR EXCEPTIONAL CIRCUMSTANCE - *CHILD*

This parent/guardian has applied for Child Care Subsidy due to a medical and/or exceptional circumstance for their child. The information that you provide will assist us in assessing their application and determining eligibility.

Parent/Guardian Information (please print):

Parent/Guardian: _____

Address: _____ **Phone Number:** _____

Name of Child: _____ **Birth Date**: _____

I authorize the below listed Doctor/Referral Agency/Other Community Professional to complete this referral and to forward this information to the authorized representative of Halton Region.

I authorize Halton Region staff to contact me via my home/work/cell phone number if additional information is required.

I authorize the release of information and give permission to exchange information between the Social and Community Services Department at Halton Region and this agency/individual/professional for the purpose of determining eligibility for the Child Care Subsidy.

Parent /Guardian Signature: _____ **Date:** _____

Referring Agency/Doctor		Agency/Doctor's Stamp
Agency/Doctor's Name		
Phone Number		
Contact Name		
Professional Designation		

How will child care support the child's specific needs (For example: The child has Prader Willi Syndrome and would benefit from being in a child care setting that provides him/her with same-age role models for many developmental tasks as a part of his/her treatment plan):

Reason for Referral		Additional information to support referral required:
☐ Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder ☐ Autism Spectrum Disorder ☐ Biological ☐ Down Syndrome ☐ Established/Genetics ☐ Fetal Alcohol Spectrum Disorder	☐ Medical Needs ☐ Sensory ☐ Social Needs ☐ Speech Language Delay ☐ Trauma (please explain) ☐ Other (please explain)	

Other community supports currently being accessed, referred to or considered for the child and family:

Estimated length of time child care is needed:
Start Date:_____ **Update Required/End Date:**_____ **(12 month maximum)**
Type of Care:
☐Part-time Child Care (1-4 days) ☐ Full-time Child Care (5 days)
☐ Before School ☐ After School ☐ Before and After School ☐ School Age School Break Care

Signature of Referring Professional: **Date:**

_____ _____

This form should be returned to:
Halton Region, Children Services, Social & Community Services
690 Dorval Drive, Oakville, ON L6K 3X9
Fax: 905-825-8821 Attention Child Care Representative_____ 905-825-6000 ext.:_____

Personal information on this form will be used to document your consent to obtain social/medical information from the professional(s) identified above. The information collected will be used to assess your eligibility for child care services. Personal information is collected pursuant to section 71 of the *Child Care and Early Years Act, 2014*, S.O. 2014, c.11, Sched 1 and Regulations made under that Act, and will be used to administer Halton Region's Child Care Services Program. Questions about the collection of your personal information should be directed to your Child Care Representative or the Manager Direct Child Care Services, 690 Dorval Drive, 5th floor, Oakville, ON, L6K 3X9, 905-825-6000 or toll free at 1-866-441-5866.