

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: Email completed application to OLAF@hamilton.ca

Therapeutic Program Coordinator, 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

Email to: OLAF@hamilton.ca

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.

Are you submitting a Special Needs Referral – For children who may need additional supports or accommodations in the classroom / program.

OR,

Are you submitting a Therapeutic Referral – For children who would benefit from social or early learning experiences but do not require classroom supports.

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 (D/M/Y)		Date of Birth (D/M/Y)			
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: INFORMATION ABOUT ALL CHILDREN IN THE HOME

Child Care Required	Last Name	First Name	Date of Birth (D/M/Y)	Gender Identity
<input type="checkbox"/>				

Does the family want to apply for Child Care Fee Subsidy (financial assistance)?

Yes (**if yes, complete the household income section**) No

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 (D/M/Y)	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	Type of referral	<input type="checkbox"/> New	<input type="checkbox"/> Update
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PART B – SECTION 1: INDICATE CONCERNS THAT APPLY TO CHILD

<input type="checkbox"/> Expressive or <input type="checkbox"/> Receptive Speech/Language Delays	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical & Motor Development
<input type="checkbox"/> Communication Concerns	<input type="checkbox"/> Special Needs Diagnosis	<input type="checkbox"/> Victim or Witness of Abuse
<input type="checkbox"/> Developmental Delays		
<input type="checkbox"/> 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 (D/M/Y)	Gender Identity
Date of most recent visit with parent (D/M/Y)		Type of referral	<input type="checkbox"/> New <input type="checkbox"/> Update

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

<input type="checkbox"/> Cognitive	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Physical limitations - child
<input type="checkbox"/> Medications that Impair Mental Functioning	<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/> Physical Injury Treatment	<input type="checkbox"/> 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

<input type="checkbox"/> Permanent/Ongoing <input type="checkbox"/> 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 Works at least 20 hours/week Attends School Full Time Other (use section 3 to explain)**PART B – SECTION 3: ADDITIONAL COMMENTS/CONCERNS****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 on-going referring agent I will NOT be 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:

<input type="checkbox"/> Medical Doctor	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Speech-Language Pathologist
<input type="checkbox"/> Children's Aid Worker	<input type="checkbox"/> Resource Consultant	<input type="checkbox"/> 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
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Address

Date	Phone	Fax
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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 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

<input type="checkbox"/> Approval Date (D/M/Y)	<input type="checkbox"/> Yes <input type="checkbox"/> No Sent to Community Living Hamilton (D/M/Y)
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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
 - Ron Joyce Children's Health Centre
 - Hamilton-Wentworth Catholic District School Board
 - Early Childhood Resource Consultant, Community Living Hamilton
 - Supervisors, Licensed Child Care
 - Hamilton-Wentworth District School Board
 - Early Childhood Resource Teachers, Red Hill Family Centre, City of Hamilton
 - 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.
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 result 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
(Provide Copy to Parent)

Date (Day/Month/Year)

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, program evaluation and statistical use. For more information, contact Therapeutic Program Coordinator Children's and Community Services Division, Healthy and Safe Communities Department, at 905.546.2424 ext. 6477 or 365-384-0357.