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

This parent/guardian has applied for Child Care Subsidy due to a medical and/or exceptional circumstance for themselves. 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:** _____

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

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 & Community Services Department at Halton Region and this agency/individual/professional for the purpose of determining eligibility for 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 parent's specific needs (For example: The parent experienced a motor vehicle accident and requires multiple appointments for a successful recovery. Child care will allow the parent to access appointments as part of his/her treatment plan.):

Reason for referral		**Additional information to support referral required:**
☐ Hearing/Visual Impairment	☐ Mental Health	
☐ Fetal Alcohol Spectrum Disorder	☐ Mobility	
☐ Medical Need	☐ Surgery	
	☐ Other	

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

Estimated length of time child care is needed:

Start Date:_____ **Update Required/End Date:**_____
(12 month maximum)

Child's Name and Type of Care:

Child:_____**Birth Date**: _____

☐ 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

Child:_____**Birth Date**:_____

☐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

Child:_____**Birth Date**:_____

☐ 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.