Children's Services
RC/BC Referral Form

Niagara Region
Community Services
1815 Sir Isaac Brock Way
P.O. Box 344
Thorold, ON
L2V 3Z3

905-980-6000 ext. 3897
Toll free: 1-800-263-7215
csreferrals@niagararegion.ca
www.niagararegion.ca/childcare

Referring agency submitting request: Name of program completing this form

Full Name of Referant: Name of RECE or staff completing this form

Contact Email: Email address of program completing this form

Phone: Phone number of program completing this form

Referent Signature: Digital signature of person who completed this form

Section 1: Family Information

All of the fields below **MUST** be completed in order to create an account in OCCMS.

Child's full name: _____

Child's date of birth (mm/dd/yyyy): _____

Parent/Guardian's full name: _____

Parent/Guardian's date of birth (mm/dd/yyyy): _____

Address: _____

Phone: _____

Email: _____

Which licensed child care program, licensed home child care program or EarlyON Child and Family Centre is the child attending?

What centre, home or EarlyOn is this child receiving RC or BC supports at?

Reason for Request for Assessment (RC/BC Supports):

DPS Score (if applicable):	C.A.R.E. Score (if applicable):
Speech and Language Checklist complete (if applicable): YES NO	Has child already been referred for speech supports? YES NO

Why do you think this child will benefit from service(s) requested? Include diagnosis, developmental and/or social/emotional concerns and/or medical aspects for the child.

Include any additional informatio here that the RC or BC will find helpful.

Please indicate any other community agencies involved with the family:

Service	Agency	Name	Contact Number

Notice with Respect to the Collection of Personal Information

Personal information contained in this application is collected, used and disclosed in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) under the legal authority of the Child Care and Early Years Act, 2014. Personal Information is to be used for the purpose of determining and verifying eligibility for Child Care Assistance.

Niagara Region Children's Services, and any child care service provider that provides service to my family, has my consent to release or obtain information to each other for administration of the program.

Further information regarding this collection can be obtained by contacting: Access and Privacy Office, for the Niagara Region at 905-980-6000 ext. 3779.

Parent/Guardian Signature: Digital signature of parent/guardian

Date (mm/dd/yyyy):

Please email this form to the agency that provides Resource Support to your site (see below).

Section 3: Special Needs Resource Agencies:

☐**Niagara Children's Centre**
April.shaw@niagarachildrenscentre.com
Christina.ramanauskas@niagarachildrenscentre.com

☐**Niagara Region Resource Consultants**
Ashley.Boyle@niagararegion.ca

☐**Pathstone Mental Health**
Lmorrice@pathstone.ca

☐**Family And Children's Services**
Laurie.Roberto@facsniagara.on.ca

☐**Community Living St. Catharines**
smazachowsky@clstcatharines.ca

☐**Strive**
stoth@striveniagara.ca

☐**Community Living Welland Pelham**
judybonsignore@clwellandpelham.ca

☐**Niagara Support Services**
DMalatest@ntec-nss.com

Name of Resource/Behaviour Consultant: _____

Phone Number: _____ Email: _____

Date Support will commence (mm/dd/yyyy): _____

By signing and returning this form, you are confirming that your agency has the capacity to support the family noted above. Please return this completed form and send all pages to csreferrals@niagararegion.ca.

Support Agency Signature: _____