Supported Child Development Programs
Cross Boundary Extra Staffing Request

The family must be aware of the referral and consent to it verbally

*Please initial that you have spoken to the family and that they are aware of and give consent for this referral.*_____

Today's Date:_____ Original Date of Referral to SCD:_____

General Information:

Child's Name: _____ ❑M ❑ F Date of Birth (D, M, Y): _____

Parents / Legal Guardian: _____ Phone #:_____

Address: _____

Has this family identified their child as having Aboriginal heritage? ❒ Yes ❒ No Is this a Child in Care? ❒Yes ❒ No

SCD Agency: _____

Coordinator: _____ Phone #:_____ Email:_____

Child Care Setting Name: _____

Contact (Administrator):_____ Phone #:_____ Fax #:_____

Support Guide: ☐ Completed, on Date:_____ Individual Plan: ☐ Completed, on Date: _____

(**Attach completed Support Guide and Individual Plan and Consent Form**)

☐ Preschool ☐ Group Care ☐ School Age Care ☐ Family CC ☐ LNR CC ☐ IOH

Extra Staffing Support Request Details:

Type of Services: ☐ Extra staffing support

Type of Request: ☐ New Request ☐ Renewal Request ☐ Change of hours/days ☐ Change of setting

Request is for: ☐ Shared support ☐ Individual support ☐ Short-term Support (less than 6 mos) ☐ Long-term support (6 months)

Days of the Week & Hours extra staffing is requested for (i.e. 9:30– 11:00 a.m.; 8-9 a.m. & 3-5 p.m.):

A.M. ☐M_____ ☐T _____ ☐W _____ ☐Th _____ ☐F _____

P.M. ☐M_____ ☐T _____ ☐W _____ ☐Th _____ ☐F _____

If school age, hours for professional days and school holidays: _____

Total Hours per Day: _____ Total Hours per Week: _____

Start Date: _____ Review/End Date: _____

Additional Information / Coordinator Notes:

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