Government of the District of Columbia ♦ Economic Security Administration/Child Care Services Division

Child Care Referral Form

1. If you are requesting an admission form (voucher) for child care services between the hours of 7 am to 6 pm (Monday-Friday, traditional hours), please complete sections 1-4, 6-8 on the reverse side of this form.
2. If you are requesting an admission form (voucher) for child care services for non-traditional hours (before 7 am or after 6 pm Monday –Friday or Saturday or Sunday) ***complete section 5 as well.***
    - If non-traditional child care hours are needed, proof of extended hours and days of employment is required. A letter from the employer, on company letter head, indicating work hours, should be submitted with this referral. If a letter cannot be obtained, please request a Verification of Employment form from the Office of Well Being. This form can be used to verify employment hours.
3. Additional **Required** Documentation:
    - **Health Certificate:** The current DC Universal Health Certificate (dated within 1 year of request) must be submitted for each child and include immunizations. **If the child is over the age of 1, a lead test and proof of varicella (chicken pox) vaccine is required.**
    - **Verification of Employment/Training or Education program:** The resource parent/teen parent must provide proof of employment or proof of participation in a training /education program to be eligible for an admission form. **Please provide a copy of the 2 most recent pay stubs or a letter from the employer (on letter head) that verifies work hours or a letter from training/education program that verifies enrollment along with this referral form.** *Letter should include the name of the employee, the number of hours worked, a contact name and phone number.*

Please Note:

- A completed child care referral form, a current DC Universal Health Certificate, two most recent pay stubs, (or employer/training verification letter) is needed to process an admission form. (voucher)
- If the physician has evidence the child has been exposed to Tuberculosis (TB), a TB test will be required. If not, the physician can indicate on the Health Certificate that the risk for TB is low.
- In section 6, the date of birth of the head of household (and spouse, if indicated) **must** be included to process the application.
- The application must be signed and dated by the assigned social worker and have the signature of the supervisor.
- ***Families who are supervised by CFSA in-home social workers and who are in need of a child care voucher should not apply using this form. They must apply directly to the Department of Human Services (DHS) @4001 South Capitol Street, SW, 1st Floor, Washington, DC 20032.***

Referring Social Worker, please complete the following:

Name of Child(ren):	Name of Child Development Center/Family Child Care Home:
Full Address of Child Development Center/Family Child Care Home:	Telephone Number:
Name of Director/Eligibility Worker:	E-mail AND Fax No. for Child Development Center / Family Child Care Home:

Please:

(1) Use the child care code below in the appropriate column (col.4) to indicate the type(s) of Child Care needed for children referred for service.

A. Full Day
B. After School
C. Before School
D. Before and After School
E. Non-Traditional
F. Child Care Not Required

(2) Use the following code to indicate sex of children in column 3.
F M

List all children in family and use appropriate child care code for services requested.

3. Child's Full name	2. DOB	3. Sex	4. Child care code
Child 1:			
SSN:			
Child 2:			
SSN:			
Child 3:			
SSN			
Child 4:			
SSN:			

4. Referral Source:
a. Foster Care
b. Protective Supervision
c. Teen Parent
**In-home cases must apply for voucher via DHS*

5. Reason for Referral:
(For Non-Traditional Hours Only)

[ ] Training or School (Name)__________

Hours (daily) ______ to ______

[ ] Employment- Hours per week: ________

Hours (daily)______ to ______

6. Head of Household
First\Middle Initial\Last Name

____

DOB:________ SSN:________

Address:________________
(Number and Street)

____
(City, State, and Zip Code) (Home Phone)

Primary Language Spoken : ________

For Teen Parent or Resource Parent:

Name of Employer/Training/Education Program:

____

____
(Address, city, state, zip code)

Number of Hours per week: ________

Attachment: ☐Pay Stub ☐Verification Letter

7. Spouse's Name (If applicable)

Name: ________________

DOB________________

Address:________________
(Number and Street)

____
(City, State, and Zip Code) (Home Phone)

Primary Language Spoken:________

For Teen Parent or Resource Parent:

Name of Employer/Training/Education /Program:

____

____
(Address, city, state, zip code)

Number of Hours per week: ________

Attachment: ☐Pay Stub ☐Verification Letter

8. Mother's Name (If different from 6 or 7)

Name:________________

DOB:________ Home Phone:________

Address: ________________

____
(City, State , Zip code)

For DHS Staff Only:

☐ Resource Parent has changed

Name of Former Resource Parent:________

Address:________________

DOB:________ **SSN:**________

Referring Worker Name:________ Signature:________ Date:________

Worker E-mail Address:________ Supervisor Signature:________

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information — **Parent/Guardian:** ***Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	Child's First & Middle Name:	Date of Birth:	Gender: ☐M ☐F	Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_______
Parent or Guardian Name:	Telephone: ☐Home ☐Cell ☐Work	Home Address:		Ward:
Emergency Contact Person:	Emergency Number: ☐Home ☐Cell ☐Work	City/State (if other than D.C.)		Zip code:
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other_______		Primary Care Provider (PCP):	

Part 2: Child's Health History, Examination & Recommendations — **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐LBS ☐KG	HT ☐IN ☐CM	BP: (>3 yrs) ☐NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)_______ %_______
HGB / HCT (Required for Head Start)	Vision Screening Right 20/____ Left 20/____	☐Glasses ☐Referred	Hearing Screening Pass_______ Fail_______	☐Referred

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐Referred ☐Under Rx	Language/Speech	☐ NONE	☐YES	☐Referred ☐Under Rx
Seizure	☐ NO	☐ YES	☐Referred ☐Under Rx	Development/ Behavioral	☐ NONE	☐YES	☐Referred ☐Under Rx
Diabetes	☐ NO	☐ YES	☐Referred ☐Under Rx	Other_______	☐ NONE	☐YES	☐Referred ☐Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐YES ☐NO ☐Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: ____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

____

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: ______________________/______________________/______________ Date of Birth:____/____/______
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month__________ Year__________ Verified by:______________________________ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)
HepA: (__) Meningococcal: (__) HPV: (__)

Reason:____

This is a permanent condition (___) or temporary condition (___) until ___/___/___.

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)
HepA: (__) Meningococcal: (__) HPV: (__)

______________________________ ______________________________ __________
Signature of Medical Provider Print Name or Stamp Date

Economic Security Administration/Child Care Services Division
Request for Child Care Placement Change

Date:

Staff requesting day care placement change:	Title:

Name of Child(ren) in need of day care placement change:
- ♦
- ♦
- ♦

Name and Address of Current Day Care Placement:
Center Name: Address: Telephone:
***Last day at current day care placement:**
Name and Address of New Day Care Placement:
Center Name: Address: Telephone:
***First Day at new day care placement:**

The request is being made for the following reason(s):

- O Resource Parent/Parent requesting day care placement change
- O Location
- O Child going to public school
- O Child is going to public school/need before and after care
- O Child care provider concerns
- O Placement of all children at one site
- O Summer Camp
- O Facility Closing
- O Other:

Phone No:	**Cell No:**	**Date:**
Name of Guardian/Resource Parent:		**SSN:**
Signature of person completing the form:		

(Rev. 2/16)