



Referral Form

Assisted Funding Place for Early Years Provision

Personal Details

Name of child:		Date of Birth:	
Name of Parent/Carer:			
Address (including Postcode) contact phone number and email address for Parent/Carer:			
Contact Number:			
Email Address:			

Family

Family composition:
Family income:

Reason for Referral

Please provide as much detail as you feel able to help with the decision making process:



Preferred Choice of Provision (if known)

Please indicate the preferred Parish or specific Preschool/Day Nursery/Childminder you would like to attend:										
Please indicate your preferred days, session and number of hours you would like to attend:										
Days	Mon		Tues		Wed		Thurs		Fri	
Session	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
No. Hours										

Please note that we may not be able to place the child in the chosen provision or chosen days and times, but will try and offer a suitable alternative if eligible for an assisted childcare place.

Does the child currently attend a preschool/nursery/childminder?	Y / N (delete as applicable) (if yes, please provide details below)

Referrer

Name of professional referring:	
Job title of referrer:	
Contact Number:	
Email Address:	
Please give names and contact details as appropriate of the following:	
Child's Health Visitor:	
Child's Social Worker:	
Other professionals/agencies/voluntary sector working with the child and/or family:	
Do you require a referral to the Children's Dental Service for this child? Y / N (delete as applicable)	



Please note all sections of this form MUST be fully completed and signed or it will be returned to the referrer which will delay the referral process.

I declare that the above details are true and I understand that any false or incorrect information could lead to funding being withdrawn. I understand that any information provided as part of the referral will be used to administer the referral and that it may be shared with relevant childcare provider(s), Educational Psychologist(s) and any other professionals deemed necessary to ensure the child's educational and care needs are met.

All data provided to the SEYT will be processed in accordance with the Data Protection (Bailiwick of Guernsey) Law, 2017. For more information on how SEYT uses personal data, please see our Fair Processing Notice at <https://www.gov.gg/DP> under Committee for Education, Sport & Culture – Fair Processing Notice

Signed

Parent/Main Carer's Name:	
Signature:	
Date:	

If it has not been possible to obtain a signature from the parent/main carer but the process has been explained and they wish to go ahead with a referral, please fill out the box below:

Parent/Main Carer's Name:	
Person filling out the form - please include job role:	
Reason written consent unavailable:	
Has the process and data sharing been explained to the parent/carer?	
Signature of referrer:	
Date:	

Criteria for Referrals

Children are eligible if the child and/or family meet a minimum of two of the following criteria (please tick relevant boxes):

1) Families are on a low income or in receipt of supplementary benefits	
2) The child is on a Child Protection Plan	
3) There are parental illness/disability: alcohol or drug misuse, acutely ill, disabled, or severe mental health issues	
4) The family is in acute stress: in temporary accommodation, unsupported single parent	
5) There are family dysfunction: domestic violence, inconsistent parenting, family breakdown	
6) Children have significant delay in their prime areas of learning (physical development, personal, social and emotional development and communication and language development)	
7) The parent/carer is in prison	
8) Concerns around dental decay and oral hygiene	

Completed referral forms to be sent to seyt@gov.gg