| Date of Birth:  | Name of Individual:  | CID:  |
| --- | --- | --- |
|  |
| **Referral Information** |
| Referral Source: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Relationship/Connection to Client: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| If this referral is being completed on behalf of the family has the family been informed of the referral and given consent to mail / fax to be sent to CMHA WW? | [ ]  Yes | [ ]  No |
| [ ]  **Consents are attached**  |
|  |
| **Client Information** |
| Client DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Gender:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Parent(s)/Guardian(s) Name(s):  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Childs Primary Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Primary Residence Phone #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]    | Guardian Mobile: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]  |
| Alternate Guardian Mobile: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]   | ***Please tick preferred number to contact*** |
|  |  |
|  |  |
|  |  |
| Is the applicant legally entitled to live in Canada and a resident of Ontario? (examples: citizen, landed immigrant, holder of Minister’s Permit, refugee entitled to live in Canada).**A copy of supporting documentation may be requested.** | [ ]  Yes[ ]  No  |
|  |
| **Is an interpreter required?**  |
| [ ]  Yes | [ ]  No | If yes, what language? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| ***NOTE:*** *If the family is moving out of Wellington County in the immediate future the referral should be redirected to support services in their new community*. |
|  |
| **Custody Information**  |
| Custody Arrangements: | [ ]  N/A | [ ]  Yes | [ ]  No |
| Legal Agreement:  | [ ]  Yes | [ ]  No |
| [ ]  Copy of Agreement Attached  | [ ]  Copy of Agreement on file at CMHA  WW  | [ ]  Informal Custody Agreement  in Place |
| **\*If custody arrangement in place:** | [ ]  Shared Custody | [ ]  Both Parents will attend intake  |
|  | [ ]  Parents request separate Intake Meetings  | [ ]  Both Parents aware of referral |
|  [ ]  **Copy of custody documents attached**  | [ ]  **Consents are attached** |
|  |  |
| **Diagnosis**  |
| Please state the diagnosis: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | [ ]  **Diagnosis documentation attached**  | [ ]  **Copy of diagnosis information already on file at CMHAWW**  |
| *The application will not be processed if documentation is not received with the referral. The application will be returned to referral source* |
|  |
| **Eligibility** |
| [ ]  **Family / individual has been informed that CMHA requires proof of eligibility** (i.e., letter/document from referring *Ontario* Doctor or Psychologist detailing diagnosis and signed by the corresponding physician or psychologist) |
| **NOTE**: *Documentation must be signed by a Doctor, Psychologist. Documentation signed by a nurse practitioner, physician assistant or a nurse will not be accepted by the ministry.* |
| [ ]  **Currently receiving ACSD**[ ]  **Requires Support to complete ACSD application** [ ]  **Family requesting CMHA WW to be the transfer payment agency for SSAH funds**[ ]  **Disability Tax Credit discussed**  |
| ***REMINDER:*** *Eligibility is determined by the Ministry of Community Children and Social Services as per**Special Services at Home Guidelines (April 1, 2018)* |
|  |
| **Support Services Information** |
| **Is a sibling already accessing services via Family Support Options at CMHA WW?** |
| [ ]  Yes | [ ]  No | If yes, please state the name of the coordinator: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
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|  |
|  |
| **Is the individual being referred to/on waitlist for/currently accessing other services – please check (x) below:** |
| **SERVICE** | **REFERRED** |  **WAITLIST** | **IN SERVICE** |
| Developmental Service Coordination (Compass Community Services) |[ ]  [ ]  |[ ]
| Behaviour Intervention (Compass/CMHA WW) |[ ]  [ ]  |[ ]
|  |  |  |  |
| Other (Please List) | **\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_** |  **\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |
| **Additional Information** |  |  |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Signature** |
|  |
|  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **Notes** |  |
| ***NOTE:*** *This form can be signed electronically using Microsoft Signatures Digital ID – please follow the instructions to add a signature.* |
| Please send via fax to: 1-844-437-3329Or mail to: 234 St. Patrick Street East, Fergus ON, N1M 1M6**All referrals should be addressed ATTN: Colleen Scott.** |
| ***NOTE:*** *When faxing or mailing referrals please email* *cscott@cmhaww.ca* *and provide the date of the referral and initials of the client as this will allow for an email response confirming the referral was received.* |
| CC: Client Family: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Referral Source/GP: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Other:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |