| 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*** | | | | |
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| 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?  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
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| ***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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
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| **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: 1-844-437-3329  Or 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*](mailto: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: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |