|  |  |  |
| --- | --- | --- |
| Date: Date | Name of individual: Last Name, First Name | CID: CID |

**Referral Source**: Click or tap here to enter text.

**Relationship / Connection to Client:** Click or tap here to enter text.

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 DOB:** Date of Birth **Gender:** Gender **Health card number:** Health Card Number

**Parent(s)/Guardian(s) Name(s):** Parent/Guardian 1 **/** Parent/Guardian 2 **Childs primary Address:** Address **Primary Residence Phone #:** Phone Number[ ]  **Guardian Mobile:** Phone Number[ ]  **Alternate Guardian Mobile:** Phone Number[ ] *Please tick preferred number to contact*

***Please 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 arrangements: NA** [ ] **Y** [ ] **N** [ ] Legal Agreement in place: Y [ ] N [ ]
Copy of Agreement Attached [ ]  Copy of Agreement on file at CMHAWW [ ]

**\*If custody arrangement in place:**[ ] ****Shared Custody [ ] Both Parents will attend intake[ ] Parents request separate Intake Meetings [ ] Both Parents aware of referral

[ ]  **Diagnosis documentation attached**

[ ]  **Copy of custody documents attached**

[ ]  **Consents are attached**

*The application will not be processed if documentation is not received with the referral.*

*The application will be returned to referral source.*

[ ]  **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.*

|  |  |  |
| --- | --- | --- |
| Date: Date | Name of individual: Last Name, First Name | CID: CID |

[ ]  **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).*

Is the individual already connected to a Family Support Options coordinator for SSAH or MFTD funding at CMHA WW.

Name of Coordinator: Name

Is a sibling already accessing services via Family Support Options at CMHA WW.

Name of Coordinator: Name

**Additional Information:**

Click or tap here to enter text.

Signature: ­­­­­­­­­­­­­­­­ Date: Date

Please send via fax to: 1-844-437-3329

Or mail to: 80 Waterloo Av. Guelph ON N1H 0A1

Referrals may also be dropped in person to the above address, addressed to Colleen Scott.

*NOTE: When faxing an email must also be sent to* *cscott@cmhaww.ca* *providing the date of the referral and initials of the client, this will allow for an email in reply confirming receipt of the referral.*

CC: Client Family: Click or tap here to enter text. Date: Date

 Referral Source / GP: Click or tap here to enter text. Date: Date

 Other: Click or tap here to enter text. Date: Date