|  |  |  |
| --- | --- | --- |
| Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of individual:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CID:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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 DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_\_**Health card number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent(s)/Guardian(s) Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **/** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Childs primary Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Residence Phone #:** (\_\_\_\_) \_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_[ ]  **Guardian Mobile:** (\_\_\_\_) \_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_[ ]  **Alternate Guardian Mobile:** (\_\_\_\_) \_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_[ ] *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:  \_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of individual:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name of Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Referral Source / GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_