| **Referral Date:** Date | **Client Legal Name:** Last Name, First Name | **CID (If known):** CID  |
| --- | --- | --- |
|  |
| **REFERRAL INFORMATION** |
| **Referral Source:**  | Click or tap here to enter text. |
| **Relationship/Connection to Client/ Agency Name:**  | Click or tap here to enter text. |
| **Contact Information (Phone Number & Email)** | Click or tap here to enter text. |
| **Is this referral being completed on behalf of the family?**  | [ ]  No [ ]  Yes |  |
| **Has the family been informed of the referral and given consent to mail / fax this referral to CMHA WW?** | [ ] Consents are attached [ ]  Consent given verbally |  |
| **Has family already completed the online SSAH application?** | [ ]  No [ ]  Yes |  |
|  |
| **CLIENT/CONTACT INFORMATION** |
| **Client DOB:**  | Date of Birth |
| **Gender:**  | Gender |
| **Preferred/Authentic Name:**  | Preferred Name |
| **Is the applicant legally entitled to live in Canada and a resident of Ontario? (Examples: citizen, landed immigrant, holder of a Minister’s Permit, refugee entitled to live in Canada).** | [ ]  No[ ]  Yes |
|  |  |
| **Client’s Address:** | Address |
| **Parent/Guardian 1 Name:**  | Parent/Guardian 1 |
| **Parent/Guardian 1 Address:**  | Address |
| **Parent/Guardian 1 Phone:** | Phone | **Parent/Guardian 1 Email:** | Email |
| **Parent/Guardian 2 Name:**  | Parent/Guardian 2 |
| **Parent/Guardian 2 Address:**  | Address  |
| **Parent/Guardian 2 Phone:** | Phone | **Parent/Guardian 2 Email:** |   |
| **Please indicate which parent/guardian is the primary contact:** | Primary Contact Parent |
| **Relation to the child:** | Relation to Child |
| **\*Applicants are required to provide the following documentation:****Proof of immigration status or citizenship in Canada for their child (i.e., child’s birth certificate, passport, or immigration status)****Documentation of proof of residency in Ontario (i.e., child’s school registration document, parent’s valid Ontario driver’s license, or a utility bill).** **This information does not get stored in child’s CMHA WW file. \*\*\*Documentation sent to the Ministry will need to reflect child’s legal name (as in name on birth certificate).** |
| ***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*. |
| **INTERPRETATION**  |
| **Is an interpreter required to set up an appointment?** | [ ]  No[ ]  Yes - Specify language |
| **Is interpretation required to complete SSAH application?** | [ ]  No[ ]  Yes |
| **Does family have own interpreter or a person who can interpret for them?**  | [ ]  No[ ]  Yes |
| **Will family consent to coordinator contacting this person? If so, please provide contact name and phone number/email:** | [ ]  No[ ]  YesContact Name Phone Number Email |
|  |
| **CUSTODY INFORMATION**  |
| **Custody Arrangements:**  | [ ]  N/A | [ ]  No | [ ]  Yes |
| **Is there a legal agreement?**  | [ ]  No | [ ]  Yes |
|  | [ ]  Copy of Agreement already on file at CMHA WW [ ]  Copy of Agreement Attached  |
| **If custody arrangement is in place please specify sole custodial: name parent or shared custody:**  | Is there a sole custodial parent?: [ ]  No [ ]  Yes Name ParentIs custody shared? [ ]  No [ ]  Yes |
|  |  |
| **Are both parents aware of this referral?** | [ ]  No [ ]  Yes |
| **Will both parents be part of the intake meeting?** | [ ]  No [ ]  Yes |
| **Do parents request separate intake meetings?** | [ ]  No [ ]  Yes |
|  |  |
| **ELIGIBILITY & DIAGNOSTIC INFORMATION**  |
| ***REMINDER:*** *Eligibility is determined by the Ministry of Community Children and Social Services as per**Special Services at Home Guidelines (April 1, 2018)* |
| [ ]  **Family/individual has been informed that CMHA WW requires proof of eligibility to apply for SSAH** (i.e., letter/report signed by a medical professional or psychologist that details the diagnosis) |
| **Child’s Diagnosis:**  |  |
|  | [ ]  Diagnostic letter/report attached[ ]  Diagnostic letter/report already on file at CMHA WW |
| *\*This referral must include a copy of the diagnostic information. Referrals that do not include the diagnostic information will be returned to the referral source.*  |
| ***Please ensure documentation is legible.*** |
| **SUPPORT SERVICES INFORMATION** |
| **Is a sibling already accessing services via Family Support Options at CMHA WW?** | [ ]  No[ ]  Yes |
| **Name of Sibling:** | Click or tap here to enter text. |
| **Name of Coordinator:** | Click or tap here to enter text. |
| **Is the child being referred to/on waitlist for/currently accessing other services or funding – please check (x) below:** |
| **SERVICE:** | **REFERRED** | **WAITLIST** | **IN SERVICE** |
| **Access, Information & Referral (AIR)** |[ ] [ ] [ ]
| **Developmental Service Coordination (Compass Community Services)** |[ ] [ ] [ ]
| **Behaviour Intervention** **(Compass/CMHA WW)** |[ ] [ ] [ ]
| **Other (Please List)** | Enter text | Enter text | Enter text |
| **\*\*If client is eligible for services through AIR, a referral for AIR must be made first.** |
| [ ]  **Family currently receives Assistance for Children with Severe Disabilities funding (ACSD)**[ ]  **Family has applied online for ACSD**[ ]  **If ACSD application has been completed with support, please provide service partner’s name:** Click or tap here to enter text. |
| \*If family has applied online for ACSD, parent/service partner will need to locate & forward “Applicant’s User ID” to FSO Coordinator – this includes any applications in progress or future applications once completed. The User ID # is sent via email from ssah.acsd@ontario.ca OR include in this referral. |
|  |
| **ADDITIONAL INFORMATION** |  |  |  |
| Click or tap here to enter text. |
|  |
| **SIGNATURE** |
|  |
|  | Date: Date |
| **NOTES** |  |
| ***NOTE:*** *This form can be signed electronically using Microsoft Signatures Digital ID – please follow the instructions to add a signature.* |
| **To submit the form electronically or by mail please make sure you also upload and/or print the additional documents to submit with the form:*** Supporting documentation confirming diagnosis of a developmental and/or physical disability
* Proof of birth
* Proof of residency
 |
| **Submitting Electronically:**1. Once the referral form is complete save it on your device
2. Use the secure submit file link found on the website
3. Enter your personal information, then upload the completed referral form and additional documents into the “Attach Files” box
4. Click on the green “Send Files” link
 |
| **Submitting via Mail:**1. Print and fill out the form, making sure you also have copies of the additional documents listed above with it
2. Mail to:

**234 St Patrick St E, Fergus, ON, N1M 1M6****ATTN: Lisa Miller, Children’s Services Manager** |
| 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 |