

Referral to DSO-North East Region
Fax # 705-495- 1373

Applicant Information

First Name: _____

Last Name: _____

Date of Birth (dd/mm/yy): _____

Mother's Maiden Name: _____

Marital Status: _____

Gender: _____

Residential Address: _____

City: _____

Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

E-Mail: _____

Mailing Address (if different from the residential address):

P.O. Box: _____

City: _____

Province: _____

Postal Code: _____

Indicate the nature of current inquiry/request (select all that apply):

- ☐ Information
- ☐ Residential Supports
- ☐ Community Participation Services and Supports (Day Programs)
- ☐ Caregiver Respite Services and Supports
- ☐ Professional and Specialized Services (including APSW and Clinical Support)
- ☐ Person-directed Planning
- ☐ Passport

Comments: _____

- ☐ Urgent Need

Reason for Urgent Response need: (Please check all that apply)

- ☐ Individual's unpaid primary caregiver (e.g. family member) is unable to continue providing care that is essential to the individual's health and wellbeing
- ☐ Individual has no residence or is at high risk of having no residence in the very near future
- ☐ Individual's support needs have changed to such an extent that their current support arrangement may soon become untenable and their wellbeing is likely to be at risk
- ☐ Formal and informal supports are not available to reduce the risk of harm or address the need

Potential risks that may occur in the existing situation: (Please explain risks and potential impacts)

1. _____
2. _____
3. _____
4. _____
5. _____

Indicate the current situation (select the one that best applies):

- ☐ Want to find out what might be available
- ☐ Inquiry for services in the future (two or more years from now)

- ☐ Need services now and have no MCCSS-funded developmental services
- ☐ Need a change in current services (including an addition of new services)
- ☐ In transition – current services are ending

Provide a detailed description of current situation: (Mandatory)

Indicate preferred language to consider when planning for the support needs assessment interviews:

Are there any specific special needs or accessibility issue that is important to know about?

Is there a request for interpreter services?

Is there a need for a specific location for the interviews?

Referral Information

Person Sending Referral: _____

Relationship to Individual: _____

Agency Contact Information (if applicable):

Name of Agency: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

Email: _____

Primary Contact Information

a. Primary Caregiver

Is there a primary caregiver?

☐ Yes ☐ No

If YES, who is the primary caregiver?

Date of birth required for unpaid primary caregivers (Day/Month Year)

First Name: _____

Last Name: _____

Date of Birth: _____

Relationship to Applicant:

☐ Parent

☐ Sibling

☐ Other Family Member

☐ Other caring individual who is not a relative

☐ Paid Staff

☐ Substitute Decision Maker/Guardian

☐ Other (specify): _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

E-Mail: _____

b. Primary Caregiver

Is there another primary caregiver?

☐ Yes

☐ No

If YES, who is the primary caregiver? _____

Date of birth required for unpaid primary caregivers: (Day/Month Year)

First Name: _____

Last Name: _____

Date of Birth: _____

Relationship to Applicant:

- ☐ Parent
- ☐ Sibling
- ☐ Other Family Member
- ☐ Other caring individual who is not a relative
- ☐ Paid Staff
- ☐ Substitute Decision Maker/Guardian
- ☐ Other (specify):

Address: _____

City: _____

Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

E-Mail: _____

Was the individual receiving any adult developmental services prior to July 1st, 2011?

☐ Yes ☐ No

If YES, please describe:

If NO, does the individual have a psychological assessment?

☐ Yes ☐ No

If YES, please include.

If NO, please provide any documentation that supports a developmental disability.

Example:

- Psych educational Report/Assessment
- O.T. Report
- Psychiatric or Doctor's Report

Does the individual consent to this contact being made on their behalf?

☐ Yes ☐ No

Is there a Consent and Capacity Assessment process underway?

☐ Yes

☐ No

If YES describe the specifics: _____

Is there a Substitute Decision Maker Available?

☐ Yes

☐ No

*If Substitute Decision Maker is unavailable, please provide further Direction:

Date of Referral: _____

Referral source signature: _____

Please ensure that the attached consent is signed by the applicant or the Substitute Decision Maker: _____

Please ensure to send all required documentation to ensure a timely application process.

- Proof of a developmental disability
 - Which **must** be a psychological assessment or report that uses standardized assessment tools; and,
 - It must clearly state that you have significant limitations in cognitive and adaptive functioning as defined in the *Services and Supports to Promote the Social Inclusion of Persons with a Developmental Disabilities Act, 2008*.

- Proof of Age
 - **Birth or baptismal certificate;**
 - Passport; or
 - Driver's license.
- Proof of Ontario residency
 - Rental or lease agreement;
 - **Ontario Health Card**
 - Statement of direct deposit for Ontario Disability Support Program;
 - Employer record (pay stub or letter from employer on company letterhead);
 - Mailed bank account statements (does not include automated teller receipts or bank books); or
 - Utility Bill.

Please send completed form to:

Developmental Services Ontario North East Region
391 Oak Street East
North Bay, ON P1B 1A3
Email: dso@handstfhn.ca
Fax: 705-495-1373
Telephone: 1-855-376-6376 ext. 1206