DSO
Developmental Services Ontario
Your access point for adult developmental services
North East Region

SOPDI
Services de l'Ontario pour les personnes ayant une déficience intellectuelle
Votre point d'accès pour les services aux adultes ayant une déficience intellectuelle
Région du Nord-Est

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 MCSS-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 defied 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 licence.
- 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
222 Main Street East
North Bay, ON P1B 1B1
Email: trheaume-fortin@handstfhn.ca
Fax: 705-495-1373
Telephone: 1-855-376-6376 ext. 5205