YOUTH-IN-TRANSITION PROGRAM
REFERRAL FORM

Referral Source

☐ Self

☐ Service Provider

☐ Parent/Foster Parent/Guardian

Date of referral: _____

Name of Referent: _____

Relationship to Youth: _____

Contact information for Referent: _____

Contact Information

Name of Youth: _____

Gender: M / F

Age: _____ Date of birth: _____

Phone number: (h) _____ (c) _____

Email Address: _____

Address: _____ City: _____, ON

Postal Code: _____

Service Language: English / French / other (specify: _____)

Legal guardian: _____

Alternative Contact: Name: _____

Relationship: _____

Number: _____

Current Society Status/Eligibility:

- ☐ Crown Ward
- ☐ Legal Custody Order
- ☐ Formal Customary Care Agreement
- ☐ CCYS (18yrs-21yrs)
- ☐ 21-24years (former Crown Ward)
- ☐ RYS (either in receipt or eligible to receive)

Present Living Arrangement:

- ☐ Foster Home
- ☐ Group Home
- ☐ Independent Living
- ☐ Shelter
- ☐ Home (parents)
- ☐ Other (specify)_____

Names of parents / Foster parents /Guardian: _____

Are they aware of this referral? ☐ Yes ☐ No

Who else lives in the home? _____

Education:

Is the youth in school? ☐ Yes ☐ No

If so, please provide the school name: _____

Grade/Year: _____

If not, Youth's highest level of education is: _____.

Employment:

Is youth currently employed? ☐ Yes ☐ No

If so, please provide the company name: _____

How many hours per week? _____

Reason for referral:

Check any area(s) in which youth is requesting support:

Urgent: require immediate support *Moderate:* require support but not in immediate need *Info-Only:* require resources and/or referral to community supports; will address independently	Urgent	Moderate	Info-Only
☐ Life Skills _____			
☐ Education: _____			
☐ Employment/Training: _____			
☐ Financial (Bank Account/Budgeting): _____			
☐ Health & Well Being (Mental/Physical): _____			
☐ Housing: _____			
☐ Legal: _____			
☐ Recreation/Leisure: _____			
☐ Parenting/Pregnancy: _____			
☐ Other (e.g. Identification, family, etc.): _____			

Supports:

Formal Supports

Agency/Worker Name:	Past	Current

Informal Supports: (e.g. Partner, Neighbour, Clubs/Teams, etc.)		
Name/Relationship:	**Past**	**Current**

Additional Comments:

Signatures:

My signature indicates that:

I am supportive of a referral to Hands TheFamilyHelpNetwork.ca, Youth in Transition Program.
The above written reason for referral is accurate and has been explained to me.
I give permission for this information to be shared with Hands TheFamilyHelpNetwork.ca.
I understand that Hands TheFamilyHelpNetwork.ca will create a paper and electronic file.
Hands TheFamilyHelpNetwork.ca may contact me in the future for research and evaluation purposes or to share agency related information.
I understand that Hands TheFamilyHelpNetwork.ca will contact me directly or through the referent to arrange an intake interview and that the initial service plan may be shared with the referent.

_____ _____
Parent/Guardian Date

_____ _____
Youth (12 and older MUST sign) Date

_____ _____

Signature of Referent Date

Please submit referral forms to:
Hands TheFamilyHelpNetwork.ca 37 Main Street, Box 596 Sundridge, ON P0A 1Z0 Telephone: 705-384-5225 Fax: 705-384-5808

Please see attached Consent to Release Information

Hands Mains
TheFamilyHelpNetwork.ca LeReseaudaideauxfamilles.ca

CONSENT TO EXCHANGE INFORMATION

I, _____ hereby give consent to Hands
Name of Client/Parent/Guardian

TheFamilyHelpNetwork.ca to release to/ request from _____
Name of Agency/Professional

information pertaining to _____
Name of Client/Parent/Guardian / D.O.B.

The information that shall be disclosed will consist of the following:

1. **Information included on this referral form and confirmation of eligibility with Children's Aid Society.**

for the purpose of :

Determining Eligibility for the Youth in Transition Program

In the process of gathering information to determine eligibility for this referral, agencies must meet the requirements of provincial legislation relating to the privacy of your information. In signing this consent you agree that collecting, storing, and disclosing your/your child's health information is consistent with the Personal Health Information and Privacy Act of Ontario (2004) (PHIPPA) and the Agency's privacy statement, except where required by law.

Your/your child's information, collected in this referral form, will be placed in a common database.

This consent shall remain in effect from this date until the purpose for which the information was disclosed has been achieved but no longer than one year from the date of my consent. It is understood that I can revoke this agreement at any time either verbally or in writing.

_____
Signature – Client 12 years of age or older

_____
Signature – Parent/Guardian(s)

_____
Signature of Witness

DATED THE _____ OF _____, 20_____
DAY MONTH YEAR

EXPIRY DATE: (maximum of one year) _____ OF _____, 20_____
DAY MONTH YEAR