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 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 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