

**C.M.H.A. H.K.P.R. Employment Supports Referral Form**

##### Referral / Request for Service Application Form

The mission of ***CMHA- HKPR*** is to work with individuals, families and community partners in providing services to promote and enhance the mental health and wellness of those living within the communities we serve.

|  |  |
| --- | --- |
| **A. PERSONAL INFORMATION:** |  |
| Last name:       |  Date:       |
| First name:       | Social Insurance Number :       |
| Address:   | DOB:       | Gender:        |
| City:       | Postal Code:       | County:        | Country of Citizenship:       |
| Telephone:       Can we leave a message [ ] Yes [ ] No  | Alternate #:       | Email:       |
| Language Spoken:       |  Do you Identify as Aboriginal: [ ] Yes [ ] No [ ] Unknown | Culture : |
| Current Employment Status (Check all that Apply): [ ] Employed 20 + hrs/ week [ ]  Employed under 20 hrs /week [ ]  Job Change/ Crisis [ ]  Unemployed  [ ]  Interested in Employment Skills/ Education [ ]  Volunteer Work [ ]  Self Employed [ ]  Job Advancement |
| Current Legal Status (Check One): [ ] No Legal Problems/Pardon Granted [ ]  Incarcerated [ ] On Probation [ ] Awaiting Trial [ ] On Parole [ ] NCR/ORB [ ] Court Diversion [ ] Criminal Record [ ] Unknown |
| Current Residential Status (Check One):[ ]  Hospital / Facility [ ]  Homeless [ ]  Non-Profit / Subsidized Housing [ ]  Market Rent Apartment [ ]  With Parents / Primary Caregiver [ ]  Rooming / Boarding House  |
| **B. REFERRAL SOURCE: (Check One)** |
| [ ]  **Self**  [ ]  **CMHA-HKPR (Peterborough** - Internal Transfer) Staff Completing:      [ ]  **Other** Name:       Agency (If Applicable):      Relationship to Client::       Telephone:       Email:       Consent Attached?: [ ]  Yes  |
| **C. EMERGENCY CONTACT:**  |
| NAME:      | TELEPHONE:       |
| Substitute Decision Maker? [ ] Yes [ ] No *A Substitute Decision Maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.* |
| Relationship to Client:       |
|  |

Revised 2019

|  |
| --- |
| E. WHAT OTHER SERVICES ARE YOU CURRENTLY INVOLVED? (Check all that apply and name) |
| [ ]  COMMUNITY HEALTH SERVICE: (eg. ACT Team)       [ ]  Consent attached [ ] HOSPITAL OUTPATIENT PROGRAM / SERVICE:       [ ]  Consent attached [ ] EMPLOYMENT SERVICE:       [ ]  Consent attached [ ] COMMUNITY Supports – General (List all):       [ ]  Consent attached |
| F. INCOME SOURCE:  |
| What is your Primary Source of Income?[ ]  Eligible for or Receiving Employment Insurance [ ] E.I. Parental Benefits [ ] Workplace Safety [ ] CPP [ ] Accident/Sickness/Disability Insurance [ ] Ontario Works [ ] ODSP Income Support [ ] Other:       |
| G. Education  |
| What is the highest level of Education you have attained?[ ]  Some Elementary [ ]  Completed Elementary [ ]  Some High School [ ]  High School ( OSSD) [ ]  Some College [ ]  Completed College [ ]  Some University [ ]  Completed University [ ]  Some Apprenticeship [ ]  Completed Apprenticeship/ Red Seal [ ] Other:       |
| H. Do you identify with any other barriers to Employment: [ ]  Physical / Mobility [ ]  Mental Health/ Psychiatric [ ]  Deaf / Hearing Impairment [ ]  Chronic Illness [ ]  Developmental Disability [ ]  Blind / Visually Impaired [ ]  Learning Disability [ ]  Substance Use [ ]  Agility [ ]  Head Injury/ Cognitive[ ]  Childcare Needs [ ]  Transportation  |

|  |
| --- |
|  DIAGNOSIS / HEALTH INFORMATION: |
|  Psychiatric Diagnosis:       Do you identify with a mental health concern? [ ]  Yes [ ]  No Diagnosed by (Psychiatrist):       [ ]  Anxiety [ ] Depression [ ]  Bipolar Disorder [ ]  SchizophreniaDate: [ ]  Borderline Personality Disorder [ ]  PTSD  [ ]  Other – please specify: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physical Disability/ Diagnosis:**  Diagnosed by (Doctor): Date:  |
| Other medical conditions/disabilities check any that apply:[ ]  Concurrent Disorder (Substance Abuse)[ ]  Dual Diagnosis (Intellectual Disability / Developmental Disability)[ ]  Acquired Brain Injury[ ]  Other Physical Disability please specify:       |
| Additional Comments:       |

Applicant Signature Date

Staff Signature Date

Revised 2019