

**At Work/ Au Travail Employment Program Referral Form**

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

**Important Eligibility Information- If you are already receiving employment supports from another agency, you will be ineligible for the At Work/Au travail Employment Program**

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| **A. PERSONAL INFORMATION:** | | | |  | |  | | |
| Last name: | | | | Date: | | | | |
| First name: | | | | **Health Card #** | | Social Insurance Number : | | |
| Address: | | | | DOB: | | | Gender & Preferred Pronoun(s): | |
| 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 | | | | | | | | |
| Current Legal Status (Check One):  No Legal Problems/Pardon Granted  Incarcerated On Probation Awaiting Trial On Parole  Court Diversion Criminal Record Unknown | | | | | | | | |
| Current Residential Status (Check One):  Hospital / Facility  Homeless/ Couch Surfing  Non-Profit / Subsidized Housing  Market Rent Apartment  With Parents / Primary Caregiver  Rooming / Boarding House | | | | | | | | |
|  | **B. REFERRAL SOURCE: (Check One)** | | | | | | | |
| **Self**  **CMHA-HKPR**  (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: | | | | | | | | |

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| 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  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  Deaf / Hearing Impairment  Chronic Illness  Developmental Disability  Blind / Visually Impaired  Learning Disability  Substance Use  Agility  Head Injury/ Cognitive  Childcare Needs  Transportation |

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| DIAGNOSIS / HEALTH INFORMATION: |
| Mental Health Diagnosis:       Do you identify with a mental health concern?  Yes  No Diagnosed by (Psychiatrist):        Anxiety Depression  Bipolar Disorder  Schizophrenia  Date:  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