

# Adult Services Referral

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| **Residential Referral**  **Adult Home Share**  **Shift Staffed Homes**  **Regional Services** | **Supported Living and Housing**  **Supported Independent Living**  **Cluster Housing**  **Regional Services** | **Individualized Community Resources**  **Adult Family Support**  **Adult Day Service**  **Supported Employment** |

**I am unsure of what service area to select.**

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| **REFERRAL SOURCE** | |
| **Referring worker:** |  |
| **Agency:** |  |
| **Address:** |  |
| **Email Address:** |  |
| **Phone #:** |  |
| **Fax #:** |  |
| **Date of Referral:** |  |

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| **DEMOGRAPHIC INFORMATION** | | | | |
| **Name:** | |  | | |
| **Address:** | |  | | |
| **Postal Code:** | |  | | |
| **Phone #:** | |  | | |
| **Date of Birth:** | |  | | |
| **Gender:** | | Male Female Transgender  Non-Binary | | |
| **MHSC #:** |  | | **PHIN #:** |  |
| **SAHS #:** |  | | **TREATY #:** |  |
| **BAND#:** |  | | **SIN #:** |  |

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| **LEGAL STATUS** | |
| Independent | SDM PGT Personal Care Property |
| SDM – Other | Order of Supervision |
| Other please specify: | |

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| **CLdS SPECIFIC INFORMATION** | | | | | |
| **CSW Name:** |  | | **Contact Number:** |  | |
| **EIA Worker:** |  | | **Contact Number:** |  | |
| **Has funding been confirmed?** | | Choose an item. | **SIS Level (1 to 7):** | | Choose an item. |

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| **Would this person like to have someone with them for any follow up meetings, including information gathering and intake meetings?** Please provide name, number, and relationship to the referred person. | |
| **Name:** |  |
| **Contact Information:** |  |
| **Relationship:** |  |

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| **OTHER SERVICES PERSON IS INVOLVED WITH**  **Health Professionals, other CLdS service, etc.** | | |
| **Name (First Last)** | **Phone #** | **Agency or Relationship to Person** |
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| **Family Involvement, Support and Social Network:** Include in this section people in this person’s life that help this person make informed decisions, supports the person to feel a sense of community and belonging, and offers emotional support outside of a service relationship. Also include people in this person’s life that they enjoy spending time with or who have known this person for a long time (i.e. relatives, friends, significant other, community members, community organizations, community memberships, cultural involvement). | |
| **Name:** |  |
| **Contact Information:** |  |
| **Relationship:** |  |
| **Notes re Quality of Relationship:** |  |

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| **Name:** |  |
| **Phone:** |  |
| **Notes:** |  |
| **Relationship:** |  |
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| **Name:** |  |
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| **Name:** |  |
| **Phone:** |  |
| **Notes:** |  |
| **Relationship:** |  |

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| **Physical Health Diagnosis** | No | Yes | **Physical Health Diagnosis** | No | Yes |
| If yes, type? | | | If yes, type? | | |
| **Mental Health Diagnosis** | No | Yes | **Substance Use** | No | Yes |
| If yes, type? | | | If yes, type? | | |
| **Sensory Issues** | No | Yes | **Seizure Disorder** | No | Yes |
| If yes, type? | | | If yes, type? | | |
| **Chronic Medical Conditions** | No | Yes | **Substance Use** | No | Yes |
| If yes, type? | | | If yes, type? | | |
| **Known Allergies** | No | Yes | **Languages Used** | | |
| If yes, type? | | |  | | |

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| **Communication** (e.g.: primary language spoken, ASL, verbal, non-verbal strategies, communication devices) |
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| **ASSESSMENTS/HISTORY/DOCUMENTATION *(check all that are attached)*** | | | |
| My Support Plan | Person Centered Plan | Psychological | Behavioural |
| Risk Assessment | Social History | Living Skills |  |
| Other please list: | | | |

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| **Safety and Well- Being:** Please describe areas where this person will need support to keep themselves and others safe, or strategies to manage risk associated with choice or health (i.e. eating, finances, shopping, street safety, sexual health, exploitation, aggression etc.) |
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| **Community Participation and Membership:** Please list community activities and group memberships that this person regularly engages in. Share interests and hobbies. |
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| **What support is required for this person to increase community participation and membership (i.e. exploring interests, increased experience, support etc.)?** |
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| **Connection to Culture:** Share information regarding this person’s connection to their culture, spirituality, community, language, traditions etc. What may they need to increase the connection if this is their goal? |
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| **Other involvement we should be aware of (please describe below all that apply):** |
| **Does the individual present significant risk to themselves or others in the community?** |
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| **Is the individual involved in the Criminal Justice System and under Probation or Parole conditions?** |
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| **Is the individual currently under an order with the Manitoba Board of Review (not criminally responsible)?** |
|  |
| **Does the individual have a history and/or actively engaged in a high-risk lifestyle (sex trade, gang activity or affiliation, chronic drug use etc.)?** |
|  |
| **Does the individual have an un-treated or difficult to manage co-occurring mental health diagnosis?** |
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| **Does the individual have exceptional/complex medical support needs requiring the development and oversight of complex care plans and regular occurring or ongoing specialized services from medical professionals (complex feeding assistance, complex seizure disorder etc.)?** |
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| **Is the individual aging out of CFS care and requires significant case coordination?** |
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| **Does the individual have chronic housing issues (multiple evictions, hard to house etc.)?** |
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| **Is the individual being discharged from hospital, crisis stabilization or correctional facility?** |
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| **Does the person have a recent history of victimization, abuse investigations, and protection concerns?** |
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| **Is the person at risk of self-harm, suicide threats/ideation and/or does the person have a recent history of self-harm and suicide threats/ideation?** |
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| **Does the individual have complex or unique family involvement and/or dynamics that would require significant case coordination?** |
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| **For residential referral (Shift Staffed Homes, Adult Home Share) complete part A below**  **For Supported Living and Housing (Supported Independent Living, Cluster Housing) complete part B below**  **For Individualized Community Resources (Adult Day Service, Employment and Adult Family Support) complete part C below** |

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| **PART A: RESIDENTIAL REFERRAL (Shift Staffed Homes, Adult Home Share)** |
| **Current Living Situation** (i.e. another agency, home with parents, roommates, number of staff during day/night): |
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| **Reason for Move:** |
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| **Please describe the ideal home environment for this Individual (check all that apply):** |
| Living with a Single Male  Living with a Single Female  Couple (no kids)  Family with kids  Group home setting- describe what would make an ‘ideal’ roommate.  In own home independently  At home with family  Wants to live with another person receiving support  Wants to/ needs to be the only person receiving support in the home  Wants to live with animals  Does not want to live with animals  Geographic Preference:  Smoker  Other: |
| **Please Describe the person’s accessibility and mobility support needs** |
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| **Please complete checklist to describe support for activities of daily living** |
| Independent  Partial Assistance  Complete Assist |

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| **PART B: SUPPORTED LIVING AND HOUSING (Supported Independent Living, Cluster Housing)** |
| **Housing Retention** |
| Currently homeless, couch surfing, shelter access  Unstable living situation, risk of eviction or unsafe environment  Frequent moves, requires regular help to secure/retain housing, landlord issues  Minimal assistance required, infrequent periods of instability OR 1st time on own  Stable housing, same independent living situation for more than 1 year |
| Comments: |
| **Household Maintenance** |
| |  | | --- | | Support staff must complete tasks for the individual | | Participates in completing tasks but only with support staff assistance | | Completes some tasks independently, others require support | | Completes tasks independently when reminded | | Independent- no support needed to clean and maintain home | |
| Comments: |
| **Cooking and Meal Planning** |
| |  | | --- | | Support staff must complete tasks for the individual | | Participates in completing tasks but only with support staff assistance | | Completes some tasks independently, others require support | | Completes tasks independently when reminded | | Independent- no support needed to plan, shop and cook | |
| Comments: |
| **Hygiene / Self Care Needs** |
| Support staff must complete tasks for the individual  Participates in completing tasks but only with support staff assistance  Completes some tasks independently, others require support  Completes tasks independently when reminded  Independent- no support needed to attend to personal care |
| Comments: |
| **B: COMMUNITY LIVING** |
| **Accessing Community Resources/Recreation** |
| |  | | --- | | Socially isolated and/or negative social relationships | | Few social outlets, reluctant to engage | | Will engage when supports are present | | Willing to engage but needs support to find outlets | | Independent; no social access issues | |
| Comments: |
| **Attending Appointments** |
| |  | | --- | | Socially isolated and/or negative social relationships | | Few social outlets, reluctant to engage | | Will engage when supports are present | | Willing to engage but needs support to find outlets | | Independent; no social access issues | |
| Comments: |
| **Other Systems (medical services/Home Care, employers, programs, schools)** |
| |  | | --- | | Socially isolated and/or negative social relationships | | Few social outlets, reluctant to engage | | Will engage when supports are present | | Willing to engage but needs support to find outlets | | Independent; no social access issues | |
| Comments: |
| **C: LIFELONG LEARNING** |
| **Financial/Money Management** |
| |  | | --- | | No budgeting skills, no bank account and/or refuses supports | | Requires full assistance and is vulnerable to being taken advantage of by others | | Accepts assistance but frequently does not follow plan, impulsive spending habits | | Requires and accepts assistance to budget, access bank | | Independent, manages own money effectively | |
| Comments: |
| **Public Trustee/SDM** |
| |  |  | | --- | --- | | PT/SDM for both personal and financial, requires SIL to complete financial plans | No budgeting skills, no bank account and/or refuses supports | | PT/SDM in place or need to be arranged, communication required from supports | Requires full assistance and is vulnerable to being taken advantage of by others | | Limited trustee orders in place, little or no supports required from SIL | Accepts assistance but frequently does not follow plan, impulsive spending habits | | Trustee administered by 3rd party i.e. family; minimal service support involvement | Requires and accepts assistance to budget, access bank | | No PT/SDM | Independent, manages own money effectively | |
| Comments: |
| **Literacy/Comprehension** |
| |  |  |  | | --- | --- | --- | | Illiterate and/or comprehension is significantly impeded | PT/SDM for both personal and financial, requires SIL to complete financial plans | No budgeting skills, no bank account and/or refuses supports | | Literate but comprehension affects daily living skills | PT/SDM in place or need to be arranged, communication required from supports | Requires full assistance and is vulnerable to being taken advantage of by others | | Needs assistance to comprehend but can follow directions from supports | Limited trustee orders in place, little or no supports required from SIL | Accepts assistance but frequently does not follow plan, impulsive spending habits | | Requires support to ensure comprehension of verbal and written communications | Trustee administered by 3rd party i.e. family; minimal service support involvement | Requires and accepts assistance to budget, access bank | | Can read, write and comprehend i.e. labels, letters, notices | No PT/SDM | Independent, manages own money effectively | |
| Comments: |
| **D: EMPLOYMENT** |
| **Vocational Activities** |
| |  |  | | --- | --- | |  | No program, employment or school and refuses to engage in purposeful activity | |  | Needs assistance to meet program or employment activity goals | |  | Requires shift supports to access purposeful activities currently in place | |  | Part time work, school or programming | |  | Full time work, school or programming, no supports required | |
| Comments: |
| **E: HEALTH AND SAFETY** |
| **Personal Safety** |
| |  | | --- | | History of self-harm, suicidal ideations/attempts | | Engages in risky behaviors (puts self at risk of harm, in dangerous situations) | | Vulnerable to harm from others e.g. abusive relationship, gang involvement, etc. | | Understands personal safety issues but often impulsive, makes poor choices | | No self-harm or risk of harm from others | |
| Comments: |
| **After hours support** |
| |  |  | | --- | --- | | Recurrent and persistent issues i.e. emergency services access | History of self-harm, suicidal ideations/attempts | | Would require staff intervention to manage emergencies but intermittent | Engages in risky behaviors (puts self at risk of harm, in dangerous situations) | | Would require verbal direction to manage e.g. if pipe bursts, needs to attend to ER | Vulnerable to harm from others e.g. abusive relationship, gang involvement, etc. | | Little or no engagement with emergency services or after hours supports | Understands personal safety issues but often impulsive, makes poor choices | | Independent, can manage personal or home emergencies | No self-harm or risk of harm from others | |
| Comments: |
| **Health and Medication Management** |
| |  | | --- | | Daily assistance e.g. med delivery, diabetic monitoring, compression socks | | Needs supports to assist for planning and administration but not daily | | Some assistance required but not always willing to accept supports | | Accepts supports as needed but intermittent | | Independent; manages medication and health care needs | |
| Comments: |
| **Mental Health** |
| |  | | --- | | Recurrent and persistent issues i.e. unstable mental health issues | | Frequent instability but support plan in place, crisis’ managed effectively | | Has periods of instability, seeks assistance | | Relatively stable, intermittent issues but non-critical | | No and/or stable mental health | |
| Comments: |
| **Risk To Others** |
| |  | | --- | | History of violence, sexual interference, assault, thefts, etc., safety risk to others | | Staff safety issues e.g. gender specific staff required, double staffing needed, etc. | | Verbal threats and aggression, requires de-escalation | | Property Damage issues due to acting out behaviors | | No history of violence, no risk to others | |
| Comments: |
| **F: SOCIAL** |
| **Frequency of Contact** |
| |  | | --- | | Requires daily contacts, frequently calls, emails or shows up without appointments | | Frequent contacts required but respects boundaries, appropriate interactions | | Needs regular contact but does not engage, SIL must ‘track down’ the person | | Regular but not daily contact required | | Appropriately accesses supports, respects boundaries, makes appointments | |
| Comments: |
| **Family and Other Relationships** |
| |  | | --- | | Unsafe relationships and/or requires frequent interventions | | Limited or no relationships, frequent isolation, few external supports | | Some family or other relationships but not very engaged with participant | | Supportive family and other relationships but support required to access | | No family or other relationship issues | |
| Comments: |

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| **PART C: INDIVIDUALIZED COMMUNITY RESOURCES REFERRAL (Adult Day Service, Employment and Adult Family Support)** | | | | |
| **DAY PROGRAM/SCHOOL** | | | | |
| ☐**Day Program** | Name: | | | |
| ☐**School** | Name: | | | |
| ☐**No Day Service** | * Does the individual want to attend a day program/work opportunity? ☐ Yes ☐ No * Comment on what the individual does during the day: * If ‘No’, provide School name of last school attended: | | | |
| **Last Grade Completed:** | | |  | |
| **When was this person last in school?** | | |  | |
| **Is transportation currently provided to and from day program/school?** | | | Yes  No | |
| If Yes, who is the transportation provider? | | |  | |
| If Yes, will this mode of transportation continue post move? | | | Yes  No  Unsure | |
| **SERVICE REQUEST** | | | | |
| Work Experience | | Recreation Leisure | | Social Skills |
| Basic Living Skills | | Community Awareness | | Basic Literacy |
| GED | | Sensory Processing | | Anger Management |
| Supported Employment | | Family Support | |  |

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| **EMPLOYMENT** | | |
| **What interests, skills and abilities does the person have that would help with employment exploration?** | | |
| **Has the person had prior employment?** | | Yes  No |
| **Please list previous positions held by the person, and reason for leaving:** | | |
| **Please list previous positions held by the person and reason for leaving:** | | |
| Name of Employer: |  | |
| Job Title: |  | |
| Paid/Unpaid: |  | |
| Reason for Leaving: |  | |

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| **FAMILY SUPPORTS** | |
| **Does the person currently live with family?** | Yes  No |
| **What is the purpose of support staff? Please comment on plans regarding transitioning from the family home.** | |

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| **Is There Any Other Information You Want to Share that Would Assist Us in Our Initial Understanding of the Types Of Supports this Individual Requires or Would Desire?** |
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