Resources for Exceptional Children and Youth

Children's Mental Health Transitional Activation Worker Fund

APPLICATION FORM

SECTION 1: REFERRAL PROVIDER INFORMATION

Agency Information: (*Agency submitting Application for Funds on behalf of Client***)**

Agency Name:		Date:
Name of Contact:		Position:
Address:		Telephone:
City/Town:		Fax:
Postal Code:	Email Address:	
Case Manager: *(if different from above)*		Position:
Clinical Supervisor:		Position:

SECTION 2: CLIENT INFORMATION

Child/Youth Name:		D.O.B. *(mm/dd/yy)*
Family Composition: Lives w/Both Parents ☐ Lives w/One Parent ☐ Crown Ward ☐ Justice ☐ Other ☐		
Age:	Gender:	
All Parent/Guardian Name(s):		
Custody: Two Parents/Guardians ☐ One Parent/Guardian ☐ Name _____ Other ☐ _____		
Address:		Telephone:
City/Town:		Cell or Fax:
Postal Code:	Email Address:	

SECTION 3: COMMUNITY SUPPORTS

Agency/Service	*Contact Person*	*Type of Service*	*Frequency*	*Status*

SECTION 4: HEALTH INFORMATION (*if applicable)*

Admission Date to Hospital:	Discharge Date from Hospital:
Primary Diagnosis:	Secondary Diagnosis:
Other Presenting Medical Conditions:	
Name of Psychiatrist:	Hospital Affiliation:

SECTION 5: RESIDENTIAL INFORMATION *(if applicable)*

Admission Date to Residence:	Discharge Date from Residence:
Primary Diagnosis:	Secondary Diagnosis:
Other Presenting Conditions Requiring Support:	
Name of Psychiatrist(s):	Affiliation:

SECTION 6: TRANSITION PLAN

Please specify transition plan and plan for client after transition funds have been utilized.

Goal	*Plan/Strategy*	*Timeline*	*Agency/Person Responsible*

SECTION 7: FUNDS REQUESTED

Staffing:

No. of Hours _____ x Rate of Pay $_____ x No. of Weeks _____

Total Request = $ _____

Requested Start Date (if known): _____

Cheque Payable to:

Name(s) of Referring Support Provider: _____
*(**must** carry appropriate professional liability insurance)*

Address: _____

Telephone Number: _____ Fax: _____

Email Address: _____

SIGNATURE(S) OF SUBMITTING ORGANIZATION:

Caseworker Signature: _____ Date: _____

Management Signature: _____ Date: _____

☐ Signed Communication Agreement attached (page 5)

CONSENT FOR SERVICES:

I/We hereby certify that the information contained in this application is accurate to the best of my/our knowledge and I/we hereby consent to services within the Transitional Activation Worker Fund Program for length of approval.

Youth/Adult Signature	Date
Parent / Guardian Signature	Date
Parent / Guardian Signature	Date

COMMUNICATION AGREEMENT

All application information is treated confidentially. In order to evaluate the application, and to ensure accountability for public funds, it may be necessary to clarify some of the information contained. In order to proceed with your application we may require authorization for release of information as outlined below.

I/We _____ **of** _____
(Parent/Guardian) *(Address)*

understand that clarification and/or verification of information contained in the application may be required and within those limits, **authorize Resources For Exceptional Children And Youth – Durham Region** to contact/or be contacted by the individuals/agencies/services listed below. I/We hereby waive any and all claims against Resources For Exceptional Children and Youth – Durham Region, its Board of Directors and its employees in connection with the release and disclosure of this information.

IDENTIFY and INITIAL as appropriate:

(Please initial)

[ ] Lakeridge Health Corporation

[ ] Ontario Shores Centre for Mental Health Sciences

[ ] Rouge Valley Health System

[ ] Other (please identify) _____

[ ] Other (please identify) _____

[ ] Other (please identify) _____

Regarding _____ D.O.B. _____
(Individual's Name) *(mm / dd / yy)*

Unless otherwise noted, this authorization is valid for the lesser of: the period of the approved allocation or the period necessary to reach a decision regarding the application dated _____ 20_____. (not to exceed six months).

_____ _____
(Date) *(Signature of Parent(s)/Guardian(s)*

_____ _____
(Date) *(Signature of Youth/Adult)*

_____ _____
(Date) *(Signature of Witness)*

Information is collected under the authority of the Child and Family Services Act 7(1)(6).

Please forward completed application to:

Jenna Francis, Director, Programs and Services
Resources for Exceptional Children and Youth – Durham Region
1320 Airport Boulevard
Oshawa, ON L1J 0C6
E-mail: jfrancis@rfecydurham.com
Fax: 905-427-3107