

REGIONAL CHILDREN'S CENTRE

Name: _____

EMHware #: _____

COORDINATED SERVICE PLANNING REFERRAL PACKAGE

The purpose of this referral package is to help connect families and their child/youth who are experiencing multiple and/or complex special needs to Coordinated Service Planning. The objective of Coordinated Service Planning is to provide children and youth with multiple and/or complex special needs with seamless and family-centered supports within the community. Once the package is completed, if eligible, families will have access to a Coordinated Service Planner. This is someone who will work collaboratively with the family to identify their child/youth's goals, strengths and needs. Once established, the Coordinated Service Planner will act as the family's primary contact, inviting the family's team of community providers to work collaboratively towards meeting their goals.

Referrals to Coordinate Service Planning should be made in parallel to referrals to other services, particularly if there is a wait for Coordinated Service Planning. Being referred to Coordinate Service Planning should not prevent a family from accessing other appropriate services.

Coordinated Service Planning is not a required point of access or a gatekeeper and Service Planning Coordinators are not responsible for determining eligibility for other programs.

The referral package includes the following sections:

1. Screening Tool: To meet eligibility requirements for the program, you must answer YES to the **first four** questions. The Screening Tool can be revisited at any time as circumstances change.
2. Referral Form: Please be sure to include which 'Tier' of service is needed.

Client Information			
Last Name:		First Name:	
		Child/Youth's Preferred Name and Pronouns:	
		DOB:	
Gender:	Sex Marker on Legal Identity Documents:		Phone #:
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X		
Address:			
Contact Information			
Name, pronoun and relationship of parent(s)/guardian(s):			
Primary Contact:		Relationship with Client:	
Phone #1:		Phone #2:	
Phone number and best time to reach them:		Parent/Guardian email address (optional):	
Address and phone number (if different than child's):			



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Custody agreement:	
Names, pronouns and ages of siblings in the same home:	
Language(s) spoken: Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Do you self-identify as Indigenous to Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Transportation required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any safety concerns:	
Any other accommodation requirements:	

Step 1: Screening Tool

Date Screening Tool Completed	
Name of Agency Completing the Tool	

Please answer the following questions regarding the identified child/youth *If Answer YES to first 4 questions:	
1. Child/youth is age 0-18 OR age 18-21 and still in school	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the child/youth have multiple and/or complex special needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please select all that apply: <input type="checkbox"/> Query of/or a diagnosis related to special needs <input type="checkbox"/> Physical <input type="checkbox"/> Communication <input type="checkbox"/> Emotional and/or Behavioural <input type="checkbox"/> Social <input type="checkbox"/> Medical (medically fragile) <input type="checkbox"/> Intellectual <input type="checkbox"/> Other: _____
3. Is the child/youth currently receiving more than one service/support, or anticipated to start?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify: _____



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<p>4. Is the family experiencing barriers to coordinating services for their child/youth?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please select all that apply:</p> <p><input type="checkbox"/> Coping strengths and adaptability</p> <p><input type="checkbox"/> Health and well-being of other family members</p> <p><input type="checkbox"/> Literacy and/or language barriers</p> <p><input type="checkbox"/> Limited social/community supports</p> <p><input type="checkbox"/> Competing demands: _____</p> <p><input type="checkbox"/> Caregiving/employment</p> <p><input type="checkbox"/> Financial instability</p> <p><input type="checkbox"/> Other: _____</p>
<p>5. Is the child/youth and/or family already involved with service providers?</p>	<p><input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>If the child/youth/family is not already involved with needed service providers, please make these referrals at this time.</p>
<p>6. Is the family suitable for Coordinated Service Planning?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

***If already involved with service providers, please indicate below:**

Provider	Receiving	Waiting for / in need
Rehab services (OT, PT, SLP)	<input type="checkbox"/>	<input type="checkbox"/>
Autism Services / Developmental Services	<input type="checkbox"/>	<input type="checkbox"/>
Early Childhood Development Support	<input type="checkbox"/>	<input type="checkbox"/>
Respite Supports	<input type="checkbox"/>	<input type="checkbox"/>
Children's Aid Society	<input type="checkbox"/>	<input type="checkbox"/>
Special Education Supports	<input type="checkbox"/>	<input type="checkbox"/>
Clinical / Mental Health Supports	<input type="checkbox"/>	<input type="checkbox"/>
LHIN Nursing Supports	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQIA2S+ Identity Supports	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to the first four questions, please proceed to the referral form on the next page.



HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

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Step 2: Referral to Coordinated Service Planning

Health and Medical Concerns including Diagnosis (if applicable):

Child, Youth and Family Strengths (please list at least 2-3):

What is working well?

What do you hope to see changed as a result of Coordinated Service Planning Involvement?
(ex. Improved communication across service providers, increased parent confidence in navigating their child/youth's care, completion of a coordinated service plan, etc).

List Current Services this child/youth family is receiving and what support they provide, as well as a contact person for each service:

Referrals can be emailed to HDGHCoordinatedServicePlanning@hdgh.org or faxed to 519-257-5212.