Community Support Referral Form

Please return this form by fax to 905-225-1279 or email admin@reachniagara.com

Client Information

First Name:_____ Last Name: _____ Birthday (DD/MM/YYYY):_____

Phone: _____Gender:____ Address: _____City: _____

HIFIS # (if known): _____ # Months of homelessness in the past year:_____

Referral Source Information

Name:_____ Phone: _____ Fax:_____

Name of Agency:_____ Email: _____

Client requires support with the following: (check all that apply):

- ☐ Primary Care
- ☐ Identification assistance
- ☐ ODSP Support
- ☐ Mental Health or Substance Use Counseling
- ☐ System Navigation (i.e., financial connection, community referrals, etc.)
- ☐ Addiction Support
- ☐ Other:_____

History of or current substance use: ☐ YES ☐ NO

If applicable, please select the program of interest: ☐ PATH ☐ JSTICE ☐ HART Hub

Source of Income:

- ☐ Ontario Works
- ☐ ODSP
- ☐ CPP
- ☐ Employment
- ☐ Old Age Security (OAS)
- ☐ Other:_____

Additional Information:

_____

_____

_____

_____

_____

Consent (Please Review and Initial)

☐ Client has verbally consented to the disclosure of their personal health information for the purposes of a referral to REACH Niagara

☐ Email only - I understand that email is not a secure means of communication and understand the risks. REACH's privacy statement can be reviewed at:

https://reachniagara.com/about/privacy-policy/