



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: JUSTICE Addiction's Program

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/>