LANARK HEALTH & COMMUNITY SERVICES

# FAMILY RELIEF PROGRAM

30 Bennett St., Unit 1

Carleton Place, ON K7C 4J9

257-7619 or 1-866-257-7618

Fax: 257-2209

## FAMILY RELIEF PROGRAM REFERRAL

### Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

**Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MailingAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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### Custody Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Referral Agent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical: (diagnosis/severity of condition; diagnosing physician; medications; behaviours in school/home; other special needs kids)

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Reason for referral: (parents state of health/mental health, employment/marital status, # dependants,)

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Involvement with: (other agencies; doctors/schools; previous ACSD/SSAH funding)

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***For Office Use Only***

**Funding possibilities: \_\_\_\_ACSD \_\_\_\_ SSAH \_\_\_\_\_\_ASD \_\_\_\_ER**

**Income (applicable to ACSD only): \_\_\_OW \_\_\_ODSP \_\_\_\_ less than $64, 000**

**Who receives Child Tax Credit**:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Disability Tax Credit Nav database FRR10 \_\_\_\_\_\_\_\_

\_\_\_ Easter Seals Added to monthly Stats\_\_\_\_\_\_\_\_

\_\_\_Jump Start Letter mailed to family\_\_\_\_\_\_\_\_\_

Intake Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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