HÔTEL-DIEU GRACE HEALTHCARE

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.

<table>
<tr><th colspan="4">Client Information</th></tr>
<tr><td>Last Name:</td><td>First Name:</td><td colspan="2">Child/Youth's Preferred Name and Pronouns:
DOB:</td></tr>
<tr><td>Gender:</td><td colspan="2">Sex Marker on Legal Identity Documents:
☐ Male ☐ Female ☐ X</td><td>Phone #:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><th colspan="4">Contact Information</th></tr>
<tr><td colspan="4">Name, pronoun and relationship of parent(s)/guardian(s):</td></tr>
<tr><td>Primary Contact:</td><td>Relationship with Client:</td><td>Phone #1:</td><td>Phone #2:</td></tr>
<tr><td colspan="2">Phone number and best time to reach them:</td><td colspan="2">Parent/Guardian email address (optional):</td></tr>
<tr><td colspan="4">Address and phone number (if different than child's):</td></tr>
</table>

HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

REGIONAL CHILDREN'S CENTRE

Name: _____

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Custody agreement:	
Names, pronouns and ages of siblings in the same home:	
Language(s) spoken: Interpreter required: ☐ Yes ☐ No Comments:	Do you self-identify as Indigenous to Canada? ☐ Yes ☐ No Comments:
Transportation required? ☐ Yes ☐ 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	☐ Yes ☐ No
2. Does the child/youth have multiple and/or complex special needs?	☐ Yes ☐ No If YES, please select all that apply: ☐ Query of/or a diagnosis related to special needs ☐ Physical ☐ Communication ☐ Emotional and/or Behavioural ☐ Social ☐ Medical (medically fragile) ☐ Intellectual ☐ Other: _____
3. Is the child/youth currently receiving more than one service/support, or anticipated to start?	☐ Yes ☐ No If YES, please specify: _____

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

***If already involved with service providers, please indicate below:**		
Provider	**Receiving**	**Waiting for / in need**
Rehab services (OT, PT, SLP)	☐	☐
Autism Services / Developmental Services	☐	☐
Early Childhood Development Support	☐	☐
Respite Supports	☐	☐
Children's Aid Society	☐	☐
Special Education Supports	☐	☐
Clinical / Mental Health Supports	☐	☐
LHIN Nursing Supports	☐	☐
LGBTQIA2S+ Identity Supports	☐	☐
Other:	☐	☐

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

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REGIONAL CHILDREN'S CENTRE

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Step 2: Referral to Coordinated Service Planning

There are 3 tiers of service. Please select which tier this referral is for:	
Tier 1: Consultation – Referring Community Agency staff to as Coordinated Service Planner and to complete Coordinated Service Plan in consultation with an HDGH Coordinated Service Planner	☐
Tier 2: Partnership – The coordination and facilitation of the Coordinated Service Planning program will be provided using a collaborative process between the referring agency and a representative from the HDGH CSP team.	☐
Tier 3: Service Planning Coordination – An HDGH Coordinated Service Planner is required to lead 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.