AIR Referral information and fillable PDF.

General Information:

Please find enclosed the material you will need to make a referral to Access Information & Referral for children's developmental services and supports in Guelph and Wellington County. There is no fee for the individual user.

Eligibility:

Ministry Funded services and supports are available to individuals up to the age of 18 who have an intellectual disability and/or an autism spectrum disorder. Eligibility also relies on confirmation of proof of the child/youth immigration status or citizenship in Canada, as well as being a resident of Guelph and Wellington County.

This documentation is required with the submission of a referral to AIR, and may be any of the following: **proof of your immigration status or citizenship in Canada** (such as your Ontario or other Canadian province or territory birth certificate, certificate of Indian status, Canadian citizenship, Canadian passport, Permanent Resident card, or Immigration, Refugees and Citizenship Canada letter).

A referral can be made by the individual or their legal guardian. AIR will also accept referrals from extended family members, family physicians, or any agency acting on the individual's/family's behalf, as long as the consent section in the fillable form below has been completed in full by the referral source, the individual (16 years of age with capacity) or their guardian.

NOTE *Please include all applicable documentation to this referral package. ie: Diagnostic documentation, custody documents as required, confirmation that the consent section is completed in full and proof of Canadian citizenship / immigration status as required above. Insufficient documentation will delay this process.*

Documentation in the form of an assessment report/letter which confirms a diagnosis of an autism spectrum disorder and/or an intellectual disability is required. Please note that a letter simply stating a diagnosis without providing supporting assessment information and relation to the DSM-5 criteria is not sufficient to confirm eligibility for AIR and subsequent MCCSS funded developmental services. For eligibility criteria, please refer to the AIR web page available at www.compasscs.org

Once the referral package is completed, please send the fillable PDF along with all required supporting documentation to AIR@compasscs.org or faxed to attention AIR at 519-824-3598 or by mail to: AIR, 20 Shelldale crescent, Guelph N1H1C8

Questions pertaining to our agency's policies regarding eligibility for children, please contact AIR directly. AIR Contact Information: Email: AIR@compasscs.org Phone: 1-800-307-7078 option 4

What Happens Next?

After receiving a completed referral form and the required supporting documentation verifying eligibility for AIR and MCCSS funded services, you will receive a Referral Confirmation letter by mail or email within 3-5 days, this letter will include if the individual has been deemed eligible, and/or if the referral is missing any documentation to determine eligibility. Then, depending on the reason for referral (listed in the AIR Referral Form below), the AIR Service Coordinator will follow up with you accordingly. Please note, if you are requesting a follow-up which requires an appointment with AIR, wait times can be 3 - 5 months.

Looking for Developmental Services for 0-4 years old, and 18+ years old:
Eligibility for adult developmental services, 18 years or older, is determined by **Developmental Services Ontario (DSO)**. Please call 519-894-1153, Ext. 2907 or 2910 to make a referral to DSO. The referral process may start at 16.5 years old.

For services and supports for children aged 0-4, please contact **HERE4KIDS** 1-844-4KIDS-11 (1-844-454-3711) to speak to a service coordinator about linking to services for challenges relating to their child's speech, movement, play, behaviour, learning and/or development

Thank you for your Referral.

AIR Client Referral Form

Date of Referral: _____

Client Information

Client Name First: _____ Middle: _____ Last:_____

Date of Birth (Day / Month / Year) :_____ Age: _____ Gender: _____

Clients Address: _____ _____ _____

_____ _____.

Diagnosis: ASD ☐ Intellectual Disability ☐ Both ☐ Other _____

School Attending _____ Day Care Attending _____

Parent /Guardian Information

Parent / Guardian Name (s): _____, _____

Address (If different from Client's): _____

Primary Contact Name: _____

Primary Contact Phone : _____ E-Mail _____

Alternate Guardian Phone : _____

Preferred method of contact:_____

Custody Information:

Custody Agreement In place: N/A ☐ YES ☐ NO ☐

Legal Agreement in place : YES ☐ NO ☐

If YES, Please ATTACH custody agreement- I have attached the custody agreement : ☐

If there is NO formal agreement in place, kindly provide information regarding the details of parent(s) concerning the individual. Additionally, offer an overview of their parental status and specify the individual responsible for making treatment decisions.

_____.

_____.

_____.

*Incomplete Information will delay the referral process.

Referral Source (if parent is referral source, skip this section)

Client/Parent/Guardian permission received to facilitate this referral: YES ☐ NO ☐

Referred by: _____

Agency name / Address: _____ _____.

_____ _____ _____

Phone number of referral source: _____

Email of referral source: _____

A consent form signed by client ☐ Legal Guardian ☐ attached. ☐

I have attached the consent form to this referral: YES ☐

Alternatively if Verbal consent is given please complete the following:

Verbal Consent given : YES ☐ By who: _____

Relationship to child : _____ Date verbal permission given : _____

Statement: I _____, have given verbal permission to (referring worker name)

_____ from (agency/ school board) _____ to share

individuals personal information with AIR for the purpose of _____.

Additional Details Required

Clients Family Doctor's Name: _____

Doctors address: _____

Doctors Phone Number: _____

Health Card Number: _____

Is the Applicant legally entitled to live in Canada and is a resident of Ontario? (examples: Citizen, landed Immigrant, holder of a Minister's Permit, refugee entitled to live in Canada). YES ☐ NO ☐

Note* a copy of supporting documentation may be requested.

Clients Siblings names and DOB (if applicable)

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Interpretation Required? YES ☐ NO ☐ Language: _____

Reason for this referral

NOTE* All services requested requiring an appointment will take 3-5 months. Check all that are applicable. (If none are applicable please note in the section below).

- ☐ Verify eligibility for MCCSS Services, (even if no supports are currently needed).
- ☐ Submit an SSAH referral to CMHA - Agency Administration Referral
- ☐ Schedule a meeting with the AIR coordinator to explore services and supports (1-2 hour meeting).
- ☐ Engage in discussions about MCCSS behavioural services.
- ☐ Explore MCCSS funded respite services.
- ☐ Opt to receive an informational email about inclusive recreational community services.
- ☐ Opt to receive an informational email about available funding resources.

Please Indicate which services/resources you are currently accessing and which you would like to discuss further.

Service / Resource	Applied for or registered and accessing	Would like further information
Access 2 Entertainment Card	☐	☐
PAL Card	☐	☐
Kerry's Place Autism Services	☐	☐
Kids Ability	☐	☐
CMHAWW	☐	☐
DCAFS/ Coordinated Service Planning	☐	☐
Hopewell Children's Homes	☐	☐
Ontario Autism Program	☐	☐
Special Services at Home (SSAH)	☐	☐
Disability Tax Credit	☐	☐
Easter Seals Incontinence Grant	☐	☐
Assistance for Children with Severe disabilities (ACSD)	☐	☐
Ontario Health	☐	☐
Dufferin Wellington FASD	☐	☐

Additional Information:

_____

_____

_____

_____

_____

_____
_____
_____
_____.

Please Note: * AIR does not provide information or make necessary referrals for the following rehabilitation services:

Speech & Language therapy, Occupational Therapy or Physiotherapy. Please connect with Kids Ability or Ontario Health.

***For services and supports for those children aged 0-4, Parents can contact HERE4KIDS** 1-844-4KIDS-11 (1-844-454-3711) to speak to a service coordinator about linking to services for challenges relating to their child's speech, movement, play, behaviour, learning and/or development.

Referral Checklist

Completed all sections of the AIR Client Referral Form: YES ☐

Attached Consents from referral source: YES ☐ or N/A ☐

Attached Diagnostic Information: YES ☐

Attached Custody Agreement (if applicable): YES ☐

Attached Proof of immigration status/ Canadian citizenship : YES ☐