Dear Care Provider,

Thank you for contacting *Intake* at Halton Support Services. An intake package is included in this document, which must be complete in order to access our services. ***Please include documentation from a physician indicating the person’s developmental diagnosis*.** If you are interested in our services, please forward the completed package back to the email indicated below. If criterion is met, you will be contacted to complete Ministry-funded applications and discuss community resources.

If you require additional information regarding this process or assistance with completing this package please do not hesitate to contact our office at (905) 844-7864 ext. 221 or email: awedekind@cwsds.ca

Sincerely,

Aleda Wedekind

*Intake Coordinator*

**Intake Package for Halton Support Services**

**Person’s Name** **Date of Birth:** \_\_\_/\_\_\_/\_\_\_
 Last First month day year

**Gender: Male** [ ]  **Female** [ ]  **Self-identify as:**

**Home Address:**

**City/Town: Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family/Care Provider Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Individual:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis(es):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Documentation confirming diagnosis is attached: Yes** [ ]  **No** [ ]

**Medical Concerns: Seizures** **Yes** [ ]  **No** [ ]
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioural, Social and/or Emotional Concerns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safety Concerns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History/Relationships**

**Person Resides With:**
**Parents:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sibling(s):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information (that should be noted):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services Requested: (please check all that apply)**

[ ]  Caregiver Respite
[ ]  Recreation and Community Resources
[ ]  Service Coordination

**Special Services at Home Program (SSAH)**

Have you applied to SSAH? Yes [ ]  No [ ]
Do you receive currently receive SSAH funding? Yes [ ]  No [ ]  If yes, how much annually?

**Assistance for Children with a Severe Disability Benefit (ACSD)**  *This is a low to moderate* ***income based*** *program to assist children with disabilities living under parental care. The benefit provides caregivers financial assistance to meet ongoing extraordinary costs arising from the disability.*

Have you applied for, or currently receiving, the ACSD benefit? Yes [ ]  No [ ]

Do you require additional information about this program? Yes [ ]  No [ ]

Please send completed form with attached diagnosis documentation to: **Halton Support Services,
53 Bond Street, Oakville ON L6K 1L8 Phone: 905 844 7864 ext.221 Fax: 905-849-6980 E-mail:** **awedekind@cwsds.ca**

**Consent to Disclosure of Information:**

The following are a network of agencies providing services to children and adults with developmental disabilities in the Halton Region. These agencies include:

**Bob Rumball Association for the Deaf Community Living North Halton**

**Central West Specialized Developmental Services Community Living Oakville**

**Christian Horizons Kerry’s Place Autism Services**

**Community Living Burlington Regional Municipality of Halton**

**Community Care Access Centre Children’s Aid Society (CAS)**

**Reach Out Centre for Kids (ROCK) ErinoakKids**

**Halton Public School Board Halton Catholic School Board**

**Woodview (Mental Health and Autism Services)**

The undersigned hereby consents to and authorizes Halton Support Services to release the above noted personal information and any further personal information collected pertaining to the above noted applicant to the agency/agencies listed above, for obtaining services.

Please indicate if you have an agency of preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this \_\_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_\_\_\_\_\_\_\_\_\_

 (Day i.e. Monday) (Date i.e. 1st) (Month) (Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Signature of Parent/Legal Guardian (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness

Please direct all questions pertaining to the above information to *Intake* at Halton Support Services

 (905) 844-7864 x 221