



When you need help with the most difficult job in the world.

DIVERSION SERVICES REFERRAL FORM

I am referring myself

Date: _____

I am submitting a referral on the behalf of the caregiver(s)

Agency Name _____

Contact Name _____

Phone _____

Email _____

Caregiver(s) Name _____

How did you hear about Haven Family Support? _____

Marital Status _____

DOB (mm/dd/yyyy) _____

Street Address _____

Ethnicity _____

Phone Number _____

City _____

Best time of day to contact caregiver: _____

Caregiver employed outside the home? Yes No

Attending School? Yes No

What are the times that work best for a Family Support worker to visit? _____

Reason for Referral: What do you feel a Family Support worker could do for the family? _____

Household Information: Please list the individuals that are living in the home at the time of this application.

Name Age Gender Relationship to you Other Factors

Name	Age	Gender	Relationship to you	Other Factors



HISTORY

Are you aware of any of the following issues (past or current)? If so, please elaborate and indicate which family member(s) the issue applies to. This information enables us to better match a Family Support worker with your family. Please be assured that all information will be kept confidential.

- Inappropriate (includes lack of) Discipline: _____
- Lack of Supervision: _____
- Inappropriate Caregiver(s): _____
- Domestic Violence: _____
- Physical Neglect: _____
- Emotional Neglect: _____
- Home Cleanliness: _____
- Physical Abuse: _____
- Sexual Abuse: _____
- Verbal Abuse: _____
- Cognitive Limitations: _____
- Mental Health: _____
- Physical Disability or Health: _____
- Difficult Behaviour: _____
- Alcohol Abuse (specify past/current): _____
- Drug Abuse (specify past/current): _____
- Methadone: _____
- Gang Affiliation: _____
- Parent Aide Safety Concerns: _____
- Other (use additional page if necessary): _____

CONFIDENTIALITY

All information will remain confidential, although we are required to do a name check only with Social Services in order to avoid duplication of services. If necessary, Haven Family Support may have contact with the referring agency.

Caregiver(s) Signature _____

Agency Signature (if applicable) _____

Referrals can be returned in person at our office, through mail or by fax at 306.974.3170.

Address: 502 Avenue L South Saskatoon, SK S7M 2H4

Thank you for completing this application form and for your interest in our program. If you have difficulty in returning this form, please call our Director at 974-3172 to make alternative arrangements.

FOR OFFICE USE ONLY:

Assigned to parent aide: _____	Phone: _____
Number of hours per week: _____	Date: _____
Parent Aide Director _____	
