

PLEASE READ BEFORE COMPLETING FORM

This form is to refer a senior (55+) who is a New Westminster resident that is in need of Independent Living supports. **This is not an application for housing.** Seniors Services Society is not a housing provider or housing placement service. For non-emergency referrals and general information for seniors call 604-520-6621.

INDEPENDENT LIVING SERVICES
<ul style="list-style-type: none"> • For seniors 55+ • Outreach services are provided to New Westminster clients only • Worker assists client in stabilizing health and finances

IMPORTANT POINTS

The worker must initial the added clause in the medical section to consider this form completed.

- **Service will not be delivered without client consent.** We require both **signed client consent** (see attached Release of Information Form) as well as **verbal contact** with the client. We can begin preliminary assessment of the client with written client consent only; however we will need to speak to the client directly before delivering service. Please ensure there is accurate contact information for the client.
- Please double check that all sections of this form are completed before sending. If you are not able to obtain the information yourself please have the client call us directly.
- Be sure to include a number where you (the referrer) can be reached, as we will need to verify information with you. If you are a social worker at a hospital, please include your specific location and pager number.
- Please avoid medical acronyms.
- Note that Seniors Services Society reserves the right to refuse services for a variety of reasons such as
 - ❖ Caseloads may be at maximum capacity
 - ❖ Client may be located out of our service area
 - ❖ Our services may not meet the needs or be appropriate for this particular client
 - ❖ Our services may not meet client expectations

In the case of any of the above we will make every effort to refer the client to other agencies serving senior individuals.

*****SERVICES WILL NOT BE DELIVERED WITHOUT CLIENT CONSENT*****

Seniors Services Society Client Referral Form



* ARE MANDATORY.

* Client's Name: _____ * Age: _____

Referrer Information

Today's Date _____

* Your Name _____

* Your Agency _____

Your Contact _____

Client Information

Basic Info	* Client's Full Name _____
	* DOB (dd/mm/yyyy) _____
	* Client Contact Number(s) _____
	* Residency in BC <input type="checkbox"/> 1+ yrs <input type="checkbox"/> Less than 1 yr <input type="checkbox"/> Unknown <input type="checkbox"/> Not a resident
	* Preferred Language _____ * Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	* <input type="checkbox"/> Veteran

Additional Info	* What is the reason for this referral?
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Income	Monthly Gross Income (Before Deductions) \$ _____					
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Is the Client on Income Assistance?</td> <td style="width: 15%; padding: 5px;"><input type="checkbox"/> No</td> <td style="padding: 5px;">Other Income Source(s) <i>i.e.</i> CPP, OAS:</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Yes</td> <td style="padding: 5px;"><input type="checkbox"/> Employable <input type="checkbox"/> PPMB <input type="checkbox"/> PWD</td> <td style="padding: 5px;"></td> </tr> </table>	Is the Client on Income Assistance?	<input type="checkbox"/> No	Other Income Source(s) <i>i.e.</i> CPP, OAS:	<input type="checkbox"/> Yes	<input type="checkbox"/> Employable <input type="checkbox"/> PPMB <input type="checkbox"/> PWD
Is the Client on Income Assistance?	<input type="checkbox"/> No	Other Income Source(s) <i>i.e.</i> CPP, OAS:				
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Contacts Name: _____ Phone Number: _____ Relationship: _____

Housing Is client At Risk Homeless

Reason: _____

Medical *Medical Contacts (Family doctor, Mental Health worker etc.)

Name _____ Phone _____

Name _____ Phone _____

*Physical Health Issues _____

*Mental Health Issues _____

*History of Substance Abuse: No Yes

Describe _____

SSS reserves the right to deny assistance to a client referred by any health authority that does not provide follow up services to clients. _____ Please initial.

Complete the following ONLY if the client is currently in hospital.

Hospital Hospital Name _____

Date of Admission (dd/mm/yyyy) _____

Discharge Date (dd/mm/yyyy) _____

Admitted For _____

Social Worker _____ Phone _____

Send **completed** forms with signed *Release of Information Form* (below) to

Seniors Services Society **FAX:** 604-520-1798

MAIL: 209 – 800 McBride Blvd., New Westminster, BC V3L 2B8

NO SERVICES WILL BE DELIVERED WITHOUT CLIENT CONSENT

Please call 604-520-6621 if you have not received confirmation of receipt within 2 business days.



209-800 McBride Blvd. New Westminster BC V3L 2B8. Phone: 604-520-6621. Fax: 604-520-1798

Release of Information Form

*This form has been designed to comply with the **Personal Information Protection Act, S.B.C. 2003, c. 63** to ensure confidentiality and to make provisions for the exchange of relevant personal and service-related information between service providers.*

As part of the process of assisting you, we will collect some information about you and your situation. We use this information to understand your needs. In some cases, we might need to confer with referring agencies or other service providers while we are trying to help you find housing and/or support services.

As well, we also collect general statistical data about our clients for funding reports, social service research, and for public relations purposes. These statistics never contain identifying information.

If you agree to allow the Seniors Services Society to use your information in this way, please complete the following:

I, _____ DOB: _____

hereby authorize the release of information to the staff of *Seniors Services Society*, and further, authorize them to release information from my file as necessary, while assisting my search for housing and/or support services.

I understand that information will only be shared as necessary for the provision of services, and that I may revoke this consent at any time, either verbally or in writing.

Signature

Date

Witness

Date