Thrive Program Referral Form

Date (d/m/y): ________________________

Name:		Age:
D.O.B:	Gender & Pronouns:	
Phone Number:	Alternate Number:	
Email Address:		
Street Address:	Postal Code:	
Preferred Contact Method (Call/Text/Email):		

If you are completing this referral on behalf of a young person, we encourage you to do so alongside the individual

Please complete as much of this form as possible. This form is used to get a better understanding of an individual's current circumstances. Responses given on this form will not be used for the purposes of excluding individuals from programming. Please only answer the questions that you feel comfortable answering.

Reason for Referral

____
____
____
____

Education Status

What was your last grade completed in school? ____

Do you have any high school credits? Yes No
If yes, how many credits do you have? ____
____

Have you had any educational assessment(s) completed? Yes No
Describe any learning challenges identified or not identified: ____________________
____
____
____

Did you receive accommodations or modifications in courses while enrolled in the traditional school system? If so, what accommodations/modifications did you receive? ____________________
____
____
____

Thrive Program Referral Form

Date (d/m/y): ________________________

Housing/Living Arrangement

Do you have a safe place to live? Yes No

What is your current living arrangement?

☐ Living Alone ☐ Living with Family or Friends

Group Home Bedsitter

Shelter Other:__________________________________

Do you have any subsidies for housing? Yes No

If you have subsidies, do you know which ones?____

Have you (or anyone else) submitted applications for housing? Yes No

Other Supports

What is your source of income? ____

Have you filed taxes for the most recent tax year? _______________________________________

What transportation will you use to get to class? ____

Do you have any children? Yes No

If yes, do you have childcare (daycare, parents)? Yes No

If yes, do you have a CSSD file? Yes No

Are there any other things that impact your ability (barriers) to participate in an education program that you would like us to know about?____

____

____

____

Is there anything else that you would like us to know?_____________________________________

____

____

____

Thrive Program Referral Form

Date (d/m/y): ________________________

Support Network

Support	Check	Name
Case Manager		
Social Worker		
Child Protection/Youth Services		
Corrections		
Substance Use Support		
Housing Support		
Therapist/Counsellor		
Community		
Other Education Support		
Family Member		
Primary Care Provider/Family Doctor		
Other:		

It's important to note that unless you list your support(s) on the Consent to Obtain/Release Information form (page 5), we are unable to speak with your support network

If this is not a self-referral, please fill out the following:

Name:	Bus. Phone: Alternate Phone:	
Email:		Fax Number:
When is the best time to contact you?:		
What is your preferred method of contact?		

<u>**Completed referral forms can be submitted to us by email, fax, mail, or drop off.**</u>

Email: dhepditch@thrivecyn.ca   Fax: 754-0842   Mail: P.O. Box 26067, St. John's, NL, A1E 0A5

Office Drop Off: 807 Water Street, St. John's, NL   Phone: 746-9826 or 754-0536 ext. 214

Thrive Program Referral Form

Date (d/m/y): ________________________

Consent for Data Collection

I, ____, give Thrive, CYN, permission to add me to or access the Arms database through my SIN number or other identifying client ID.

Signature (Participant): ____

Signature (Staff): ____

Date (d/m/y): ______________________________

Thrive Program Referral Form

Date (d/m/y): ________________________

Consent to Obtain/Release Information

I ____________________________ give my permission and consent of my own free will for the gathering/release of information relating to my involvement in and community connections made through **Thrive Programs**.

Thrive staff person(s) is/are granted permission to obtain information from the following organization(s) and/or staff person(s):

Organization	Staff Person(s)

This consent is valid for one year from: ____________ to ____________

______________________________ ______________________

Signature of Participant Date (d/m/y)

______________________________ ______________________

Signature of Parent/Caregiver Date (d/m/y)

______________________________ ______________________

Witness Date (d/m/y)