The HEAL Network Referral Information

The HEAL Network is a partnership of 19 social service agencies in the Region of Peel.

Each year thousands of children are exposed to domestic violence in Ontario. The focus of the HEAL programs is on CHILDREN. We work primarily with Moms (and their children in a family context) to help support healing from witnessing domestic violence. Although we work primarily with Moms and children, we are Dad friendly and encourage co-operative parenting wherever possible.

The HEAL Network programs are for women helping their children heal from their exposure to domestic violence. Our programs include psycho-educational workshops, counselling, and groups.

- All programs are free
- Cultural interpreters are available
- Women of all religious and ethnic backgrounds are welcome
- Programs are offered in Mississauga and Brampton
- Assistance with transportation is provided
- Most of our programs provide a nutritious snack or meal.

General Eligibility Criteria:
If the referring family does not fit our general eligibility criteria, please call us for more information on how we can support the family at this time.

- ✓ HEAL only works with mothers and children
- ✓ Family is no longer living with abusive partner
- ✓ Family has been separated from abusive partner for 3 months or longer
- ✓ Family's immediate needs have been met (i.e. shelter, financial support, etc.)
- ✓ Family is ready and willing to engage in services

How to fill out the form:

- ✓ Inform mom of HEAL services and ensure she is ready and willing to engage in services
- ✓ If possible, fill out the form with mom present to gather all of the relevant information
- ✓ Ensure you fill out the form completely
- ✓ If you have any questions while filling out the form, please call us for support

Contact information:

HEAL Intake Line: 905-450-1608 ext.119
HEAL Program Coordinator: Diwany Selvarasa 905-450-1608 ext.155
HEAL Program Supervisor: Saima Zaheer 905-450-1608 ext.111

Please fax completed referral form to 905-450-8902

The HEAL Network
helping end abuse for life

HEAL Network Referral Form

Please complete 2 page referral form and fax to: 905-450-8902

Referring Agency: _____ **Date**: _____

Referring Staff: _____ **Phone number:** _____

E-mail address: _____ **Fax number:** _____

Client Information:

Name: _____ _____ **Date of birth:** ____ /____ /_____
First Last MM DD YYYY

Address: _____ _____ **ON** _____ _____
Street City Postal Code

Home: (___) _____ **Cell:** (___) _____ **Email:** _____

Is it safe to leave a message? YES / NO (Check all that apply) Home ☐ Cell ☐

Important Information:

Relationship status: Single☐ Common-law☐ Married☐ Separated☐ Divorced☐ Other_____

Current living situation: Alone☐ With Partner☐ With Family/Friends☐ Shelter☐ Other_____

Custody: Interim ☐ Sole ☐ Joint ☐ Undetermined ☐ Other: _____

Length of separation *(if applicable)*: _____

Gender: _____ **Gross Family Income: $** _____

Religion: _____ **Ethnic Background:** _____

Children's Information:

Child's First Name	Child's Last Name	Date of Birth mm/dd/yyyy	Gender	Age

Service Preferences:

Which location can you travel to? Brampton ☐ Mississauga ☐

Services preferred in: English ☐ French ☐ Other *(if available):* _____

Does client require Interpreter: Yes ☐ No ☐ Preferred Language: _____

Does client identify as: Francophone, Aboriginal, Inuit, Metis or First Nation? *(If yes, please circle one)*

Are you obtaining support from other places/people? Yes ☐ No ☐

Services accessed (check all that apply):

☐ School Social Worker	☐ Ontario Works / ODSP
☐ Counselling Services	☐ Shelter
☐ Immigration/Settlement	☐ Children's Aid Society
☐ Psychiatrist / Psychologist	☐ Housing Support
☐ Family Physician	☐ Legal Aid

Safety concerns for Mom (if any):_____
_____

Safety concerns for Children (if any):_____
_____

What issues does the client currently identify for her children?
_____
_____
_____
_____

I have explained to the client that in *some* cases the father may need to be contacted in order for the child to receive services with the HEAL Network. I have verbal consent from the client so that I may be contacted by the HEAL Network regarding the outcome of this referral.

Client's Signature: _____ **Date:** _____

Worker's Signature: _____ **Date:** _____