**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***

***If you do not have access to a fax machine, please call our intake line at***

***905-450-1608 ext.119***

**HEAL Network Referral Form**

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

***If you are unable to fax, please call 905-450-1608 ext. 119***

**Referring Agency:**       **Date (MM/DD/YY)**:

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

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

**Client Information:**

**Name (Full Name):**  **Date of birth (MM/DD/YY):**

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

**Contact Information - 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** |
|       |       |       |       |       |
|       |       |       |       |       |
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|       |       |       |       |       |

**Service Preferences:**

Which location can the client 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)*

Is the client 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 |

Has the client accessed support from the Safe Centre of Peel? Yes [ ]  No [ ]

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:**