



Coordinated Access Package

ADULT SERVICES

Instruction Sheet

ACCESS Form (page 2 and 3)

The **ACCESS Form** must be completed with/on behalf of each individual being referred to CSCN.

If you are completing the ACCESS Form (pages 2 and 3) manually, please **print** ensuring that the document is legible.

Forms completed electronically can be sent to CSCN by e-mail if you wish: general@cscn.on.ca

Forms not submitted electronically should be sent to the CSCN London office by mail, courier or fax.

ACCESS Report Format (page 4 and 5)

Pages four and five outline the format to be used when preparing an **ACCESS Report** with/on behalf of an individual being referred to CSCN for service coordination.

The format is **not** intended to be a fill in the blanks document. It is an outline of the information **required** in the **ACCESS Report**.

ACCESS Reports will likely be photocopied/faxed as the process unfolds, therefore, to ensure that reports remain legible, hand written documents will not be accepted.

ACCESS Consent Form (page 6 and 7)

The **ACCESS Consent Form** must be completed in its entirety and **must** be received by CSCN before the Resolution Process can commence.

This '**informed consent**' will allow Agency Service Coordinators to share information with CSCN. It also allows CSCN to share information with service providers (as appropriate) throughout the Resolution Process.

If referring an individual/family to CSCN, please ensure that the CSCN box is checked (✓) in section one of the consent form.

Referral for Accommodation Supports

Individuals being referred to the Community Services Coordination Network for the provision of **accommodation supports** must submit the following documentation:

- ACCESS Form (page 2 and 3)
- ACCESS Consent Form (page 6)
- Request for Accommodation Supports (Page 8)
- Accommodation Supports Questionnaire (page 9)
- When resources become available, CSCN will request a current ACCESS Report from the Agency Service Coordinator

Toll Free Tel.
1-877-480-2726

Toll Free Fax
1-877-462-1509

London | Middlesex
171 Queens Avenue
Suite 750
London, ON N6A 5J7
Tel. (519) 438-4783
Fax (519) 673-1509

Huron | Perth
West Perth Town Hall
169 St. David Street
Mitchell, ON N0K 1N0
Tel. (519) 348-0562
Fax (519) 348-0663

Oxford | Elgin
Aylmer Community Centre
25 Centre Street
Aylmer, ON N5H 2Z4
Tel. (519) 765-2082
Fax (519) 765-2106

SECTION THREE: Support Network

Who is directly involved in supporting the individual in the community? Please specify parents, family members, neighbours, friends, professional and agency contacts.

Name	Relationship	Address	Telephone Number
Individual Support Agreement Coordinator			

SECTION FOUR: Communication

A. Barriers to Communication No Yes If yes, go to section B.

B. Explain barrier to communication:

Interpreter Required No Yes Interpreter is Requested Will be provided by individual

Interpreter's Name: Relationship: Telephone: ()

SECTION FIVE: Accessibility

A. Physical Accessibility Needs No Yes If yes, please explain

SECTION SIX: Agency Service Coordinator Information

Last Name	First Name	Agency Affiliation
Position/Title	E-mail Address	
Mailing Address	City/Town	Postal Code
Telephone	FAX Number	

SECTION SEVEN: Resolution Teams

If there are any agencies/individuals that the individual/family would prefer not participate in the Resolution Process please list

The **ACCESS Report** is a brief summary of information that will provide a foundation for planning and decision-making. The report format that follows is intended to assist Agency Service Coordinators during the preparation of this report. All of the information requested in the report format must be provided. The **ACCESS Report** should be concise, typically, no longer than 2 or 3 pages. Any recent agency report that continues to be an accurate reflection of the individual's current situation will be accepted as the **ACCESS Report**. Any information not contained in the existing report (that is required in the **ACCESS Report**) must be submitted as an addendum.

1. Reason for Request

- Please provide a brief overview of the current situation

2. Complexity of Support

- When completing this section, please consider the following:
 - ❑ Approximately how many hours of support, per day or week, would the individual require?
 - ❑ Would he/she require an awake or asleep night staff? One to one support some of the time or all of the time?
 - ❑ Will the safety and security of others be a concern?
 - ❑ What are the physical, emotional and/or behavioural needs of the individual?
 - ❑ Is the individual able to manage/direct his or her own support?
 - ❑ Will he/she require support in order to facilitate community involvement?
 - ❑ Are there specific requirements with respect to supervision or monitoring?
 - ❑ Is support required with tasks of daily living?
 - ❑ Is support required to manage medication(s)?

3. Family Situation

- Please provide information regarding the ability of family and/or friends to support this individual.
 - ❑ Is there an active support circle?
 - ❑ Are there any informal supports currently in place?
 - ❑ What has occurred that has led to this request for service?
 - ❑ Describe the circumstances that have necessitated this request.

4. Current Supports

- If applicable, please describe the supports currently utilized by the individual and family (i.e., respite, day or leisure supports etc.).
- Are they currently meeting the individual's needs?

5. Additional Information

- What are the consequences to the individual and/or family of not receiving additional supports?
- Please provide any other information not reported in the previous sections, that will assist in understanding the individual and/or family circumstances.



ACCESS Consent Form
(See back of form for instructions)

I, _____, _____ of _____
Last Name First Name Address

hereby consent to the sharing of information to and from the following:

- Local/Service System Resolution Team
- Community Services Coordination Network
- WrapAround
- Other (please specify) _____

In respect of (select at least one)

- Myself Name: _____ Date of Birth: _____
- Child/Youth Name: _____ Date of Birth: _____
- An Adult With a Developmental Disability Name: _____ Date of Birth: _____

For the purpose of (select at least one)

- Service Coordination Other (please specify) _____

Description of the information to be shared (select one):

- Any pertinent information
- Specifically the following information:

This consent is valid for the following period: (select one)

- One year from date of signature
- Other (specify length of time from date of signature) _____

I understand that I may revoke this consent in writing at any time.

Signature Relationship (if applicable) Date

ACCESS Consent Form

Instructions for completion

- If the consent form is being completed manually, please print ensuring that the document is legible
 - The form must be completed in its entirety, i.e., each statement (bold text) must be followed by a response
 - Forms completed incorrectly will be returned. This will delay the process
 - Consent must be **informed** – the individual giving consent to share information must understand the intent
 - In order to be valid the consent form must be **both** signed and dated
-

Service Coordination

Local/Service System Resolution Teams

The Coordinated Access to Service model includes a two level resolution process (Local and Service System).

In order to facilitate effective service coordination, representatives from various community agencies will be asked to participate in the 'resolution' process. In order to ensure that the most appropriate, helpful plan is developed, Resolution Team members will review personal information that is pertinent to the service coordination process.

Once the **ACCESS Consent Form** is signed by an appropriate individual capable of giving consent on their own behalf or by an individual with the authority to consent to the disclosure of information on behalf of another individual, i.e., a parent on behalf of a minor child) relevant information may be shared with members of the resolution team as appropriate.

Resolution teams MAY include representation from any of the following program areas:

Children's Services

- Children's Mental Health
- Child Welfare
- Family Service Agency
- Developmental Services
- Board of Education and/or child's school
- Residential Service Providers
- Probation Services
- Health
- Special Services at Home
- Placement Student (Social Services area of study)

Adult Services

- Developmental Services
- Family Service Agency
- Employment Services
- Board of Education and/or individual's school
- Special Services at Home
- Mental Health
- Health
- Placement Student (Social Services area of study)

SECTION EIGHT: Request for Accommodation Supports

8.1 What services or supports would help at this time?

**8.2 What has been happening recently that has led to this request for services and/or supports?
Describe the circumstances.**

8.2 What attempts have been made to help the situation? What has worked? What hasn't been helpful?

SECTION NINE: Accommodation Supports Questionnaire

1. What type of accommodation support is being requested?

- 24 Hour Support
- SIL (Supported Independent Living)
- Associate Family (i.e., Family Home Program, Share Your Home Program etc.)
- No Preference
- Uncertain at this time

2. Should a resource become available, when will the requested service/support be needed?

- Immediately
- Within 1 year
- Within 2 years
- Within 2 – 5 years
- In more than 5 years
- Uncertain at this time – Comments: _____

3. Is the individual currently receiving accommodation supports from an agency?

- No
- Yes

If yes, This request is for support from a different agency
 The level of support required exceeds what is currently being provided

4. In his/her current living situation, does the individual present an immediate risk to themselves or others?

- No
 - Yes – Comments: _____
-

5. Does the individual currently live with caregivers who are no longer able to manage/provide care?

- No
 - Yes – Comments: _____
-

6. Is the individual currently in an institutional setting (i.e., psychiatric hospital, nursing home, etc.)?

- No
- Yes – Comments: _____

7. Does the individual making the request, or the family of the individual, have a preferred service agency?

- No
- Yes – Comments: _____