



Referral Form

Referral Information	
Name of Referral:	Date of Referral:
Name of Agency/Organization:	
Telephone:	Email:
<input type="checkbox"/> If self-referring, please check box and indicate date of referral above.	
Applicant Information	
First Name :	Last Name:
Date of Birth (mm/dd/yyyy)	SIN #
Primary Phone Number:	Secondary Phone Number:
Email Address:	
How would you like to be contacted? (check all that apply):	
<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Other: _____	
Do you have a mental illness diagnosis or self-identify as having mental illness?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , please describe:	

Are you currently in receipt of Employment Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you received Employment Insurance in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you worked in the last 52 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how many hours have you worked in the last 52 weeks? _____	
Are you legally allowed to work in Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current employment status (check all that apply):	
<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> If employed, on average how many hours a week do you work? _____	
Employment/ Education Goals (check all that apply):	
<input type="checkbox"/> Full Time Employment <input type="checkbox"/> Part Time Employment <input type="checkbox"/> Casual Employment <input type="checkbox"/> Volunteer <input type="checkbox"/> Return or Complete Higher Education	
Additional Information and/or Comments:	

