



## CAFC Youth Mental Health Fund Intake & Referral Form

### Client Information:

Full Name:		Date:
DOB (MM/DD/YYYY)	Pronouns: <input type="checkbox"/> She/her/hers <input type="checkbox"/> He/him/his <input type="checkbox"/> They/them	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity:	
Address:		
Email:		
Telephone:	Prefer: <input type="checkbox"/> Phone <input type="checkbox"/> Email	
Are you transitioning and/or transitioned out of care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Describe the nature of care:  <input type="checkbox"/> Involvement with MCFD <input type="checkbox"/> Involvement with Child Welfare system  <input type="checkbox"/> Foster care <input type="checkbox"/> Group home <input type="checkbox"/> Youth agreement <input type="checkbox"/> Kinship placement  <input type="checkbox"/> Had/have social worker <input type="checkbox"/> Had/have AYA agreement <input type="checkbox"/> Have/had Permanent Guardianship Order (PGO) <input type="checkbox"/> Other _____		
What best describes your current status? <input type="checkbox"/> Employed and/or Underemployed If employed, what is the job you have now? _____ What are your average weekly hours? _____ <input type="checkbox"/> Unemployed-without work and not searching for work <input type="checkbox"/> Unemployed-without work and are actively seeking work <input type="checkbox"/> In School or training <input type="checkbox"/> Planning to get into School or take training		

Self-Employed

**Support Information:**

What would you like the Youth Mental Health Fund for? (Check more than one if necessary)

Individual mental health counselling    Group mental health counselling

Groups (support groups, healing circles, land-based activities, etc.)

Culturally appropriate services (Indigenous Elders/Healers, etc.)

Alternative therapies (Music therapy, Art therapy, Dance therapy, etc.)

Do you have a goal that you are working on, or you would like to start?

Yes   My goal is:

Time Frame (by when you need to achieve the goal):

Some barriers in my life that might get in my way of achieving this goal are:

Progress:

No   I would like help with this. I am interested in: \_\_\_\_\_

Resources Required: \_\_\_\_\_





The Children's Aid Foundation of Canada (CAFC) Youth Mental Health Fund

The purpose of the Children's Aid Foundation of Canada (CAFC) Youth Mental Health Fund is to help youth transitioned/transitioning from care access mental health supports and address urgent and complex mental health challenges.

Youth eligible for support:

- Are aged 16-29 (inclusive)
- Transitioning and/or transitioned out of permanent care (or a youth agreement) when they reached the age of majority in their province; AND
- Need to access support for mental health concerns.
- A percentage of funding will be reserved for Indigenous youth who are engaged in or working towards education or employment goals.

Funds can be used to pay for therapy and/or counselling on an individual or group basis, or to access culturally appropriate approaches (e.g. support from Indigenous elders and healers), or alternative therapies (e.g. dance, music or art therapy).

We are expected to assist at least 15 youth every year, 5 of whom should be Indigenous.

The Indigenous youth will be expected to be engaged in or working towards education or employment goals. This includes Indigenous youth who are not currently studying but are working on an educational plan or youth who are unemployed but searching for employment. This could include Indigenous youth who are looking at programs to get a GED or upgrading classes to get into Post-Secondary Education (PSE) or looking into which type of schooling would help them reach their career goals. Or they need help to get employed, stay employed, change a career path or job.

We can help each of the 15 youth up to a maximum of \$1000. Preference will be given to youth who have financial hardship, are committed to starting therapy/counselling right away and complete therapy/counselling within 4 months in the year 2023.

We accept self-referrals from clients too. In this case, the client can complete this referral form and provide proof of youth from care status and date of birth.

If you have any questions, then please contact Monica Parelkar at 604-271-7600 or [monica.parelkar@ccssociety.ca](mailto:monica.parelkar@ccssociety.ca)