



**CANADIAN MENTAL
HEALTH ASSOCIATION**
Vancouver-Burnaby Branch

SUPPORTED VOLUNTEER PROGRAMS
Individual Program and Ready Set Go & Volunteer Group
175 W. Broadway Vancouver BC V5Y 1P4
ph: 604. 872-4902 ext.229 fax: 604. 872-5934

APPLICATION & REFERRAL

Please fill this out with your Mental Health Professional

NAME		PHONE	
ADDRESS		D.O.B. <input type="checkbox"/> M <input type="checkbox"/> F	
P.A.R.I.S. # (if applicable)	REFERRING THERAPIST	FACILITY	PHONE: e-mail:
<input type="checkbox"/> INDIVIDUAL Program		OR	<input type="checkbox"/> GROUP Program: <input type="checkbox"/> Fall <input type="checkbox"/> Winter/Spring Next Group: March 2010

1. As a participant, you need to:

- Have volunteering in the community as a goal
- Want to learn about your abilities and strengths to volunteer
- Want assistance to develop skills that will help you find a volunteer position
- Work towards maintaining your own recovery
- Be able to read & understand instructions in English
- Be able to honour commitments
- Be 19-65 years of age

If applying for the group program you must also be able to

- Be able to participate in a group setting
- Commit to attend 8 group sessions (2x/wk @ 2 - 2.5 hours each)

2. What is your primary mental health challenge?

3. Do you have any other significant difficulties that you want us to know about?

4. Who else helps you? (groups, organizations, family, friends, doctors, other workers, etc)

5. You need mental health support while participating in the program. Will the referrer be the support person for you? Yes No → If different from the referrer please provide their name & phone number:

6. Volunteer Goals (check as many as apply)

- | | |
|--|--|
| <input type="checkbox"/> Cultivate Personal Growth | <input type="checkbox"/> Community Involvement |
| <input type="checkbox"/> Esteem /Confidence Building | <input type="checkbox"/> Work Readiness (build stamina, establish routine, follow procedures, dependability) |
| <input type="checkbox"/> Interest Development | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Relationship Building | |

7. CONSENT FOR RELEASE OF INFORMATION

I give my permission to release information about my involvement with **Canadian Mental Health Association, Vancouver-Burnaby Branch (CMHA/VB)** to the health professional(s) named on this form.

8. Signed: _____ : **Applicant** Date: _____

9. Signed: _____ : **Referring Dr. / Therapist** Date: _____