| Date: (yy/mm/dd) |  Name of Individual: Last, First |  Date of Birth: (yy/mm/dd) | CID:       |
| --- | --- | --- | --- |
|  |
| *Incomplete Referrals will not be processed and will be returned* |
| **Client / Patient Information** |
| Home Phone: |  | Cell Phone: |       |
| Email Address: |       |
| Health Card: |  | Version code: |       |
| Preferred mode of contact:  | **[ ]**  | Home  | **[ ]**   | Cell  | **[ ]**   | Email | Can we leave a message: |  | **[ ]**  | Yes | **[ ]**  | No |
| Is an interpreter required: | **[ ]**   | Yes  | **[ ]**   | No | Language: |       |
| Family Physician:  |       |
| Gender Identity |       | Sexual Identity |       |
| Racial/Indigenous Identity |       | New Canadian (moved to Canada within the last 6 months) | **[ ]**  | Yes | [ ]  | No |
| Level of Education |       | Veteran |  | **[ ]**  | Yes | **[ ]**  | No |
| Emergency Contact |
| Name: |       | Relationship: |       |
| Home Phone: |       | Cell Phone: |       |
| Preferred mode of contact:  | **[ ]**   | Home  | **[ ]**   | Cell  | Can we leave a message:  |  | **[ ]**   | Yes  | **[ ]**   | No |
| Is an interpreter required: | **[ ]**   | Yes  | **[ ]**   | No | Language: |       |
| **Required Eligibility Checklist** |
| \***Notice:** We may review Clinical Connect and files from CMHA WW for the purpose of clarifying eligibility criteria  |  |  |
| [ ]   | 18 years-of-age or older |
| [ ]  | Must live in the Region of Waterloo or County of Wellington or have a plan to move to either area |
| [ ]  | Willing and motivated to engage with support worker on a weekly to monthly basis in goal-oriented support (monthly basis is the minimum meeting requirement). |
| [ ]  | **A primary diagnosis or clinical impression of one or more of the following serious and persistent mental health illnesses for at least two years:*** Schizophrenia spectrum or other psychotic disorders
* Bipolar or related disorders
* Anxiety or Depressive disorders

**AND**Meet at least 3 of the 5 categories of functional disability, as a result of mental illness **not** primarily relating an acquired brain injury or developmental disability:* Requires support with instrumental activities of daily living such as managing finances, managing transportation, shopping and meal preparation, house cleaning and home maintenance, managing communication and managing medications.
* Is unemployed, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history
* Safety concerns related to self or others, or exhibits inappropriate social behavior which results in intervention by the mental and/or judicial system
* Has difficulty in establishing or maintaining a personal social support system/ limitations or moderate impairment in social functioning
* Requires public financial assistance from out-of-hospital maintenance and may be unable to procure such assistance without help
 |
|  |
| **Supports Requested** |
| Connection/Referral to Community Services (e.g. OW, ODSP, DSO, Traverse Independence) |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Managing Symptoms  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Medication Management  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Social Contact & Relationship Skill-Building |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Safety and/or Crisis Planning |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Daily Living: Meal Preparation\* |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Daily Living: Housekeeping (e.g. cleaning)\* |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Household Skills Training (support and training to independently manage home skills such as meal preparation and cleaning)  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Daily Living: Laundry\* |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Using Public Transportation |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Shopping (e.g. groceries, toiletries) |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Emotional Support |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Income or Finances |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Wellness & Recovery Planning |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Legal Supports, Diversion/Court Support  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Accessing Medical Treatment Services (e.g. family doctor, foot treatment, diabetic education) |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Accessing Additional Mental Health Supports (e.g. Counselling, psychiatrist, DBT training)  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| Concurrent/Addictions Supports  |
| [ ]  | Ongoing support required | [ ]  | Time limited support | [ ]   | No support required |
| **Health & Mental Health** |
| Do you have any physical health concerns? | [ ]  | Yes | [ ]  | No |
| If yes, please list any current physical health diagnoses/concerns: |
|       |
| Do you have any mental health concerns? | [ ]  | Yes | [ ]  | No |
| If yes, please list any current or previous mental health diagnoses: |
|       |
| Please list any undiagnosed mental health concerns: |
|       |
| **Substance Use History**  |
| Do you have a substance use issue?  | [ ]  | Yes | [ ]  | No |
| How often do you use alcohol? |
|       |
| How often do you use other drugs? |
|       |
| **Emergency Services / Hospitalization History** |
| Have you been to the hospital emergency department in the last 12 months?  | [ ]  | Yes | [ ]  | No |
| *(ex. Breathing problems, anxiety/panic, depression, overdose, attempted suicide, alcohol poisoning, fights, falls, stitches, heart problems, car accident, assault, sexual assault, seizures, etc.)* |
| If yes, how many times: |       |
| What problems took you to the emergency department? |
|       |
| Have you been hospitalized in the last 12 months? | [ ]  | Yes | [ ]  | No |
| If yes, how many times: |       |
| Why were you admitted to hospital? |
|       |
| Have you accessed/been admitted to a Detox/Withdrawal Management or Police Detox “drunk tank” in the last 12 months?  | [ ]  | Yes | [ ]  | No |
| If yes, how many times: |       |
| **Housing** |
| Please describe your current housing situation *(check only one):* |
| [ ]   | No place to stay at all *(no fixed address)* | [ ]   | Temporary with friends |
| [ ]   | Hostel and/or emergency shelter | [ ]   | Mental Health Facility/Hospital  |
| [ ]   | Family home | [ ]   | Group home  |
| [ ]   | Rooming and/or boarding house  | [ ]   | Encampment |
| [ ]   | Motel and/or hotel  | [ ]  | Subsidized Apartment |
| [ ]  | Owned Home | [ ]  | Market Rent Apartment |
| [ ]  | Other (*specify):*  |       |
| Do you have any special requirements for housing such as accessibility issues, or dependent children living with you?  |
|       |
| Please explain why you have decided to apply for supportive housing *(current situation, symptoms and needs)*? |
|       |
| Are mental health issues interfering with completion of your life goals? | [ ]   | Yes  | [ ]   | No |
| **Housing Requested** |
| [ ]   | **Scattered Site Units**Intensive Off-Site Supports | [ ]   | **Congregate Home**24 Hour On-Site Mental Health Supports and some IADL Supports  |
| [ ]   | **Shared Scattered Site Units**Intensive Off-Site Supports  | [ ]   | **Congregate Home**2-8 Hour On-Site Supports and some IADL Supports  |
| [ ]   | **Scattered Site Units with Dependents**Intensive Off-Site Supports  | [ ]  | **Congregate Home**Shared Bedroom, 24 Hour On-Site IADL Supports, Off-Site Mental Health Supports  |
| Do you have a preferred location? Please rank your choices from 1 to 3. *1 = most preferred, 3 = least preferred.* |
|       | Kitchener-Waterloo |       | Cambridge |       | Guelph Wellington Dufferin |
| Are you currently on any other housing waiting lists? | [ ]   | Yes  | [ ]   | No |
| If yes, specify: |       |
| **Income** |
| What is your income source? |       |
| What is your current monthly income? |       |
| **Marital Status** |
| [ ]   | Single *(never married)* | [ ]   | Separated or divorced | [ ]   | Married/ partner/ common-law |
| [ ]   | Widow/widower | [ ]   | Number of dependents:       |
| **Legal History** |
| Are you on probation? | **[ ]**   | Yes  | **[ ]**   | No | Are you on parole? | **[ ]**   | Yes  | **[ ]**   | No |
| If yes to any above, until when? |       |
| If yes, please list conviction and conditions of probation/parole: |
|       |
| Do you have any outstanding charges, bench warrants?  | [ ]   | Yes  | [ ]   | No |
| Do you have any outstanding court dates?  | **[ ]**  | Yes  | [ ]   | No |
| Completed by (signature): |       | Date: |       |

**\*\*Once completed please fax to 1-844-HERE-FAX (844-437-3329)**

**Any Questions Please Contact us anytime at 1 844 437 3247 (HERE247) Temporary Number 226-790-4529 or TTY: 1-877-688-5501**