



Central Intake is funded by the Ministry of Health and Long Term Care and administered by Supportive Housing In Peel. It provides access to the housing and support services of partnering agencies in the Region of Peel and Etobicoke/York as well as access to the Assertive Community Treatment Teams (ACT) at Supportive Housing In Peel.

It is the policy of Central Intake to fully respect your confidentiality. However, there are certain limits on our ability or obligation to maintain confidentiality:

- 1. In providing intake services: to determine eligibility (from your written application and face-to-face meetings), match your needs to appropriate support services, maintain a record, review your continuing interest and eligibility as you wait for services, locate you through designated contacts when services become available, ensure placement services and provide a mechanism for appeal, if desired.**
- 2. In meeting legal requirements (e.g. if your file is subpoenaed or you are suspected of child abuse).**
- 3. When your behaviour poses a threat of physical harm to yourself or someone else.**

To qualify for ACT, you must give Central Intake of Supportive Housing In Peel consent to:

1. Receive or access psychiatric and hospital reports that give information on your diagnosis and past mental health hospitalizations. You must submit a signed, witnessed, and dated Consent Form to obtain reports from a doctor, psychiatrist or hospital.
2. Share information, including psychiatric, hospital or other external reports, on an as-needed basis within and between the partnering agencies for the purpose of intake and, possibly, appeal services.
3. Telephone you and leave voice mail at the locations you designate in the application form.
4. Further determine your telephone number, location or continuing interest in service through the contact of persons you designate. Please do not include the names of family, friends, or workers that you do not wish us to call.
5. Continue this agreement until the intake service and assessment is completed or you no longer wish service.

SHIP respects your privacy. The confidentiality of your personal health information is maintained through the consistent application of strict policies and procedures that are consistent with the requirements of current legislation. Your consent is required for your personal health information to be used for your care by SHIP staff or shared with anyone other than SHIP staff, where Ontario's privacy legislation allows. SHIP staff are available to explain our policy with regard to confidentiality.

Your name (first/last): _____ Birth date (M/D/Y): _____

Your signature: _____ Date (M/D/Y): _____

Supportive Housing In Peel

969 Derry Road East, Unit 107
 Mississauga, ON L5T 2J7
 T 905 795-8742 F 905 795-1129



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|--------------------------|
| ACT Team Referral |
|--------------------------|

SECTION 1:**Applicant Information** (to be completed by a Mental Health Professional)

Name: (First) _____ (Last) _____

Address: _____ Apt _____ City _____ PC _____

Telephone # _____ Date of Birth _____ Gender M / F / Unknown

Health Card # _____ Version _____

Preferred Language _____ Translator Required: Yes No

Name of Alternative Contact* _____ Relationship _____

Phone: _____

**Alternative Contact used if unable to reach applicant with numbers and address provided or in case of an emergency.*

CRITERIA FOR ASSESSMENT

| YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Applicant lives in the Region of Peel or is planning to live in Region of Peel |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Applicant has a severe and persistent mental illness (i.e.: Schizophrenia, Bipolar Disorder, Depression with recurrent psychotic features) that seriously impairs his/her functioning in community living |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Applicant has significant functional impairment in some of the following areas. (Please indicate): — basic living skills – inability to consistently carry out homemaking role — limited work skills/poor work history — inappropriate behaviour due to mental illness resulting in intervention by the mental health or judicial system — maintaining a safe living environment |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Applicant is aware of referral |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Applicant has behaviours or history of behaviours that make community visits unsafe |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Applicant is 16 years of age or older with a history of mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Applicant has history of high use of hospital services or emergency/crisis response services |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Applicant requires an intensity and extended range of services to live successfully in the community |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Applicant has treatment, rehabilitation or support needs some of the following areas (Please indicate): — intractable severe major symptoms — co-existing problems — homeless or at imminent risk of becoming homeless — unable to access traditional office-based services — currently living in a family environment but requiring a high level of support and/or causing heavy family burden |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Psychiatrist and/or treating physician are aware of the referral and agree to continue follow-up until transfer to ACTT is completed |

PLEASE CHECK APPROPRIATE YES / NO RESPONSES

SECTION 2:

Referral Source Information

Name: _____ Position: _____

Agency: _____ Phone: _____

Please indicate whether you will continue involvement with the applicant: Y / N

If No, please indicate staff member who will act as contact person:

Name: _____ Position: _____

Phone: _____

If referred to another agency who will act as contact, please provide original, signed Release of Information Forms so that Supportive Housing In Peel staff may communicate with this agency while the applicant is on wait list for the purposes of assessment and identifying service needs.

Reason for Referral and/or Applicant's Goals

Mental Health/Medical/Support Information

Diagnoses:

Primary Psychiatric Diagnosis: _____

Secondary Psychiatric Diagnosis: _____

Developmental delay/disorder: _____

Medical or physical problems: _____

Substance use issues: _____

Age of onset of mental illness: ____ years Age of first hospitalization: ____ years

Has the applicant a history of harming self/others or harming property? Y / N If Yes, please explain:

Community Supports:

(Agencies/service providers/persons involved - Supportive housing, work & volunteer agencies, community agencies, legal, etc. Include substitute decision maker if any.)

| Agency | Contact Person |
|--------|----------------|
| | |
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Applicant's Current Situation and Life Skills

Living arrangements:

- | | | | |
|------------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse & children | <input type="checkbox"/> Children | <input type="checkbox"/> Parents |
| <input type="checkbox"/> Relatives | <input type="checkbox"/> Self | <input type="checkbox"/> Friends | <input type="checkbox"/> Other |

Residence Type:

Housing: If an issue please explain: _____

- Private Apt. or House Boarding Home Subsidized living Supportive housing
- Hospital Hostel/Shelter No Fixed Address Correctional Facility

Have any housing applications been made: Y / N
If Yes, where and when: _____

Employment Status:

- Employment Assisted Independent No Employment

Primary Income Source: If an issue please explain: _____

- Employment ODSP OW (Ontario Works) Pension
- Disability Pension Family EI (Employment Insurance)

Is the applicant competent to handle finances: Yes / No

If No, please indicate current arrangement (if known): *(Public Guardian and Trustee, Power of Attorney, family member or other arrangement)*

Name: _____ Phone number: _____

Activities of Daily Living: Does the applicant require assistance with basic living skills*? Yes / No
*(*e.g. grocery shopping, cooking, cleaning, maintaining a safe living environment)*

Education:

- In school Not in School Other: _____

Legal Status:

- Court Diversion Incarceration Restraining Order Parole
- Probation Probation Peace Bond Unknown

Safety Risks (for self and/or others): _____

Other pertinent information: _____

Clinical Details (Required if NOT providing supporting documentation with these details)

Current Treatment/Prescribed Medications:

| Name of Drug/Treatment | Dosage & Frequency | Compliance |
|------------------------|--------------------|------------|
| | | |
| | | |
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Allergies: Y / N Please specify (type, severity, previous treatment):

Psychiatric Admissions: **Provide at least 2 years for ACT & 3 yrs for CTO** (A more accurate reflection of the applicant's needs over time is provided if you list all hospitalizations)

| HOSPITAL <i>Release of Information for each facility is required</i> | ADMIT DATE (day/moth/year) | DISCHARGE DATE (day/moth/year) | LENGTH OF STAY | REASON FOR ADMISSION |
|---|-------------------------------|-----------------------------------|----------------|----------------------|
| | | | | |
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Release of Information

- 1. Mail original 'Referral' with applicant's signature**
- 2. Mail original 'Release of Information' Forms***

**Supportive Housing In Peel
969 Derry Road East, Unit 107
Mississauga, ON L5T 2J7**

For questions please phone 905-795-8742

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Signature of Applicant: _____

Date: _____

Signature of Witness: _____

Date: _____

Complete and send to ACT with referral form

CAMBERWELL ASSESSMENT OF NEED Short Appraisal Schedule (CANSAS)

The CANSAS is a comprehensive assessment measure, which assesses the health and social needs of people with mental health problems across 22 domains. The CANSAS takes approximately 5 to 10 minutes to complete.

ASSESSMENT OF NEED:

Please rate the following: Please select only one option for each question:

Does the person lack a current place to stay?

- No problem (person does have an adequate home (even if in hospital currently))
- No/moderate problem due to help given (person is living in sheltered accommodation or hostel)
- Serious problem (person is homeless, precariously housed, or home lacks basic facilities such as water and electricity)
- Not known

2. Does the person have difficulty in getting enough to eat?

- No problem (able to buy and prepare meals)
- No/moderate problem due to help given (unable to prepare food and has meals provided)
- Serious Problem (very restricted diet, culturally inappropriate food)
- Not known

3. Does the person have difficulty looking after the home?

- No problem (home may be untidy but the person keeps it basically clean)
- No/moderate problem due to help given (unable to look after home and has regular domestic help)
- Serious Problem (home is dirty and a potential health hazard)
- Not known

4. Does the person have difficulty with self-care?

- No problem (appearance may be eccentric or untidy, but basically clean)
- No/moderate problem due to help given (needs and gets help with self-care)
- Serious problem (poor personal hygiene, smells)
- Not known

5. Does the person have difficulty with regular, appropriate daytime activity?

- No problem (in full-time employment, or adequately occupied with household/social activities)
- No/moderate problem due to help given (unable to occupy self, so attending day centre)
- Serious Problem (no employment of any kind and not adequately occupied with household/social activities)
- Not known

6. Does the person have any physical disability or any physical illness?

- No problem (physically well)
- No/moderate problem due to help given (physical ailment, such as high blood pressure, receiving appropriate treatment)
- Serious problem (untreated physical ailment, including side-effects)
- Not known

7. Is the person compliant with taking their prescribed medication?

- No problem (takes all medication as prescribed)
- No/moderate problem (needs prompting or assistance with filling a dosette)
- Serious Problem (non compliant with prescribed medication)
- Not known

8. Does the person have any psychotic symptoms?

- No problem (no positive symptoms, not at risk from symptoms and not on medication)
- No/moderate problem due to help given (symptoms helped by medication or other help)
- Serious Problem (currently has symptoms or at risk)
- Not known

9. Has the person had clear verbal or written information about condition and treatment?

- No problem (has received and understood adequate information)
- No moderate problem due to help given (has not received or understood all information)
- Serious Problem (has received no information)
- Not known

10. Does the person suffer from current psychological distress?

- No problem (occasional or mild distress)
- No/moderate problem due to help given (needs and gets ongoing support)
- Serious Problem (has expressed suicidal ideas during last month or has exposed themselves to serious danger)
- Not known

11. Is the person a danger to him or herself?

- No problem (no suicidal thoughts)
- No/moderate problem due to help given (suicide risk monitored by staff, receiving counseling)
- Serious Problem (distress affects life significantly, such as preventing person going out)
- Not known

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| <p>12. Is the person a current or potential risk to other people's safety?</p> <p><input type="checkbox"/> No problem (no history of violence or threatening behaviour)</p> <p><input type="checkbox"/> No/moderate problem due to help given (at risk from alcohol misuse and receiving help)</p> <p><input type="checkbox"/> Serious Problem (recent violence or threats)</p> <p><input type="checkbox"/> Not known</p> |
| <p>13. Does the person drink excessively, or have a problem controlling his or her drinking?</p> <p><input type="checkbox"/> No problem (no problem with controlling drinking)</p> <p><input type="checkbox"/> No/moderate problem due to help given (under supervision because of potential risk)</p> <p><input type="checkbox"/> Serious Problem (current drinking harmful or uncontrollable)</p> <p><input type="checkbox"/> Not known</p> |
| <p>14. Does the person have problems with drug misuse?</p> <p><input type="checkbox"/> No problem (no dependency or misuse of drugs)</p> <p><input type="checkbox"/> No/moderate problem due to help given (receiving help for dependency or misuse)</p> <p><input type="checkbox"/> Serious Problem (dependency or misuse of prescribed, non-prescribed or illegal drugs)</p> <p><input type="checkbox"/> Not known</p> |
| <p>15. Does the person need help with social contact?</p> <p><input type="checkbox"/> No problem (able to organize enough social contact, has enough friends)</p> <p><input type="checkbox"/> No/moderate problem due to help given (attends appropriate drop-in or day centre)</p> <p><input type="checkbox"/> Serious Problem (frequently feels lonely and isolated)</p> <p><input type="checkbox"/> Not known</p> |
| <p>16. Does the person have any difficulty in finding a partner or in maintaining a close relationship?</p> <p><input type="checkbox"/> No problem (satisfactory relationship or happy not having partner)</p> <p><input type="checkbox"/> No/moderate problem due to help given (receiving couple therapy, which is helpful)</p> <p><input type="checkbox"/> Serious Problem (domestic violence, wants partner)</p> <p><input type="checkbox"/> Not known</p> |
| <p>17. Does the person have difficulty looking after his or her children?</p> <p><input type="checkbox"/> No problem (no children under 18 or no problem with looking after them)</p> <p><input type="checkbox"/> No/moderate problem due to help given (difficulties with parenting and receiving help)</p> <p><input type="checkbox"/> Serious Problem (serious difficulty looking after children)</p> <p><input type="checkbox"/> Not known</p> |
| <p>18. Does the person lack basic skills in numeracy and literacy?</p> <p><input type="checkbox"/> No problem (able to read, write and understand English forms)</p> <p><input type="checkbox"/> No/moderate problem due to help given (difficulty with reading and has help from relatives)</p> <p><input type="checkbox"/> Serious Problem (difficulty with basic skills, lack of English fluency)</p> <p><input type="checkbox"/> Not known</p> |
| <p>19. Does the person have any difficulty in getting access to or using a telephone?</p> <p><input type="checkbox"/> No problem (has working telephone in house or easy access to pay phone)</p> <p><input type="checkbox"/> No/moderate problem due to help given (has to request use of telephone)</p> <p><input type="checkbox"/> Serious Problem (no access to telephone or unable to use telephone)</p> <p><input type="checkbox"/> Not known</p> |
| <p>20. Does the person have any problems using public transportation?</p> <p><input type="checkbox"/> No problem (able to use public transport, or has access to car)</p> <p><input type="checkbox"/> No/moderate problem due to help given (bus pass or other help provided with transport)</p> <p><input type="checkbox"/> Serious Problem (unable to use public transportation)</p> <p><input type="checkbox"/> Not known</p> |
| <p>21. Does the person have problems budgeting his or her money?</p> <p><input type="checkbox"/> No problem (able to buy essential items and pay bills)</p> <p><input type="checkbox"/> No/moderate problem due to help given (benefits from help with budgeting)</p> <p><input type="checkbox"/> Serious Problem (often has no money for essential items or bills)</p> <p><input type="checkbox"/> Not known</p> |
| <p>22. Is the person definitely receiving all the benefits that he or she is entitled to?</p> <p><input type="checkbox"/> No problem (receiving full entitlement of benefits)</p> <p><input type="checkbox"/> No/moderate problem due to help given (receives appropriate help in claiming benefits)</p> <p><input type="checkbox"/> Serious Problem (not sure/not receiving full entitlement of benefits)</p> |

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize _____
(Print your name) *(Print name of health information custodian)*

to disclose

my personal health information consisting of:

_____ Confirmation of serious, persistent mental illness _____

(Describe the personal health information to be disclosed)

OR

the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of: _____

(Describe the personal health information to be disclosed)

To Supportive Housing In Peel, 969 Derry Rd. E. Miss. ON
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name: _____ *Address:* _____

Home Tel.: _____ *Work Tel.:* _____

Signature: _____ *Date:* _____

Witness Name: _____ *Address:* _____

Home Tel.: _____ *Work Tel.:* _____

Signature: _____ *Date:* _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**