CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Toronto Branch

INTAKE-WEST
Lawrence Ave Site
700 Lawrence Ave West Suite 480
Toronto Ontario M6A 3B4
Tel: (416) 789-6880
Fax: (416) 789-6895
To apply for services
West of Yonge Street in Toronto

INTAKE-EAST
Markham Rd Site
1200 Markham Rd Suite 500
Scarborough Ontario M1H 3C3
Tel: (416) 289-6285 ext 243
Fax: (416) 289-4306
To apply for services
East of Yonge Street in Toronto

CMHA Toronto Programs and Application for Service (for some programs)

At CMHA Toronto we offer community support services for people living with severe and persistent mental illnesses like schizophrenia and mood disorders.

Please indicate the program (s) applying for by placing a check mark in the box attached to it.

Case Management Services

CMHA Toronto provides intensive case management services for individuals with serious mental illness who require support to live and work in the community.

Program	*Catchment Area (to apply for service using this form)*	*Criteria for Referral*	*How to apply*
☐ **Case Management-West** (West of Yonge St in TO) Service also available in French (Passages Program) AND Italian (Breakthrough Program)	• East to Yonge Street • West to Hwy 427 • North to Eglinton • South to the Lake	• 16 years of age and older • Diagnosed as having a serious mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, long-term clinical depression) • Needing assistance with activities of daily living, symptom management, socialization, education, employment, housing, etc. • Willing to accept service	-Complete this form if you reside within the outlined catchment area -**Do not use this form if you reside in Scarborough or North York** Applicants living in Scarborough and North York must apply for service with **ACCESS 1** by contacting: **1-888-640-1934**
☐ **Case Management-East** (East of Yonge St in TO) RAP (Rehabilitation Action Program) available in Tamil, Somali, Dari, Pashto, and English where culture is a barrier to participating in mental health services	• East to Victoria Park • West to Yonge Street • North to Eglinton • South to the Lake RAP (Rehabilitation Action Program) **available only in Scarborough**	• 16 years of age and older • Diagnosed as having a serious mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, long-term clinical depression) • Needing assistance with activities of daily living, symptom management, socialization, education, employment, housing, etc. • Willing to accept service • RAP provides case management service for applicants whom language or culture is a barrier to participating in mental health services	-Complete this form if you reside within the outlined catchment area -**Do not use this form if you reside in Scarborough or North York** Applicants living in Scarborough and North York must apply for service with **ACCESS 1** by contacting: **1-888-640-1934**
☐ **Transitional Youth Program**	• East to Port Union Rd • West to Victoria Park • North to Steeles • South to the Lake	• Between 16 and 22 years of age • Diagnosed as having a serious mental illness (schizophrenia, schizoaffective disorder, mood disorder) • Willing to accept service	-Complete this form if you reside within the outlined catchment area

A participant in the United Way

Assertive Community Treatment Teams (ACTT)			
ACT teams are able to provide services in the community, including people's homes. Support can be very intensive and a 24-hour on-call system is available to clients. CMHA Toronto has three ACT teams.			
Program	***Catchment Area (to apply for service using this form)***	***Criteria for Referral***	***How to apply***
West Metro ACT Team (Allen Rd-Humber River) (Steeles Ave-Eglinton Ave)	**Do not use this form** to apply for ACT Service	• 16 years of age and older • Severe and persistent mental illness (schizophrenia, schizoaffective disorder, and bipolar affective disorder) • Significant functional impairment • Continuous high service needs	-Contact **ACCESS 1** @ **1-888-640-1934**
New Dimensions ACT Team and **East Metro ACT Team** (Port Union Rd-Victoria Pk) (Steeles Ave-Lake Ontario)	**Do not use this form** to apply for ACT Service	• 16 years of age and older • Severe and persistent mental illness (schizophrenia, schizoaffective disorder, and bipolar affective disorder) • Significant functional impairment • Continuous high service needs	-Contact **ACCESS 1** @ **1-888-640-1934**
Other Specialized Programs / Services			
Program	***Catchment Area (to apply for service using this form)***	***Criteria for Referral***	***How to apply***
Mental Health and Justice Programs	**Do not use this form** To apply for MHJ Services	• Mental Health and Justice Initiatives are part of a larger, coordinated system of services for individuals with a serious mental illness who have current involvement with the criminal justice system	-MHJ Long Term Housing and Case Management Services Unit Registry: 416-757-6454 -MHJ Short Term (Safe Beds) Unit Registry: 416-248-4174 -MHJ Prevention Program (Scarborough): 416-458-9466 -Court Support and Diversion Metro West Court: 416-745-5775 Metro East Court: 416-285-4177
Mood and Psychosis Early Intervention Program (MOD)	**Do not use this form** to apply for EI Services	• Persons aged 16-34 • Living within the catchment area: Finch to Lakeshore, Islington to Victoria Park • Are presenting to mental health services for the first time with psychosis and / or a mood disorder • Have either not received treatment or have had less than one year of treatment	-Contact EI Intake @ 416-289-6880 or 416-789-7957 ext 253
Community Treatment Order (CTO) Case Management	**Do not use this form** to apply for CTO Case Management Services	• Intensive Case Management Services for people who are on CTO's living in Toronto	-Referrals are accepted from CAMH CTO coordinators and physicians
NAMI Family-to-Family Education Program (this course is offered at the Lawrence Ave West site and at the Markham Rd site	**Do not use this form**	• The NAMI Family-to-Family Education Program is a free 12-week course for family members and friends of persons living with mental illness.	-Contact 416-789-7957 ext 270 to inquire about upcoming dates and to register

Other Specialized Programs / Services (Cont.)

Program	*Catchment Area (to apply for service using this form)*	*Criteria for Referral*	*How to apply*
Housing Services	**Do not use this form** to apply for Housing Services	• CMHA Toronto Branch is participating in The Toronto Mental Health & Addictions Supportive Housing Network. The Network has been established to streamline access to supportive housing in Toronto. By applying to the Network, you can be considered for housing offered by all participating agencies.	-Contact the Coordinated Access Network Office at: **416-979-1994** OR visit the website at: **http://hsn-registry.roxysoftware.com**
Employment Services	**Do not use this form** to apply for Employment Services	• Employment Services provides comprehensive employment assistance to people with mental illness through programs funded by Service Canada, ODSP and programs supporting people on long term disability	-Contact the Employment Program: West of Yonge St: 416-789-7957 adults 30+ ext 228 youth ext 332 East of Yonge St: 416-289-6285 adults 30+ ext 305 youth ext 302

Social Opportunities

Program	*Catchment Area (to apply for service using this form)*	*Criteria for Referral*	*How to apply*
WHAT NEXT! Peer Support Program	**Do not use this form** We are conveniently located at Sheppard Avenue West & Chesswood Drive - west of Downsview subway station **3701 Chesswood Drive Suite 208**	• What Next! Peer Support Drop In Centre is a membership driven meeting place where people recovering from mental health and addiction issues can share with others and gain social and emotional support	-Contact What Next @ 416-449-4555 to arrange a visit
Social Resource Centres	**Do not use this form** -SRC Toronto location: 2700 Dufferin Street Unit 56 -SRC Scarborough: 25 Neilson Rd	• Attendance is restricted to clients of CMHA and Reconnect Mental Health Services	-Can not apply externally
☐ **Keele Street Women's Group** (Assistance in developing social support networks, life skills and community resources)	Group is held at 2700 Dufferin St (south of Lawrence Ave)	• Women 16 years of age and older • Diagnosed as having a serious mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, long-term clinical depression) • Experiencing social isolation	-Complete this form to apply for Keele Street Women's Group
Let's Discuss It / Multicultural Women's Wellness Groups	**Do not use this form**	• Women who are socially isolated and experiencing cultural and linguistic barriers, and / or at risk of mental health problems due to difficult life circumstances	-416-289-6285 ext 303 (for Afghan, Greek, Hindi, Jamaican, Polish, Punjabi, Russian and Tamil groups in Toronto) -416-289-6285 ext 301 (for Somali, Tamil and English groups in Scarborough, and Italian groups in North York)

Applicant Information

First Name: ________________________________ Last Name: ________________________________

Street Address: ________________________________ Apt. No: ________________________________

City: ________________________________ Postal Code: ________________________________

Telephone No: ________________________________ Date of Birth: Day ____ Month ____ Year_____ Age: ___

Gender: ________________________________

If you do not have a phone is there someone with whom you are in regular contact with that we can call in order to reach you?

Name: ________________________________ Telephone No: ______________________________

Relationship to applicant: ____

Language(s) Spoken: _____________________________ Preferred language: ____________________________

Language for receiving and consenting to treatment: ____

How well do you communicate in English: ☐ fluently ☐ fairly well ☐ with difficulty ☐ not at all

If unable, is there a family member who speaks English fairly well? ☐ Yes ☐ No

Do you have communication needs? (Example: hearing impaired, visual impairment, aphasia, non verbal, AAC user)

Please explain: ____

Referral Source Information (if not a self referral)

First Name: ___________________________________ Last Name: ___________________________________

Agency: ___________________________________ Title / Position: _________________________________

Address: ___________________________________ City: _________________ Postal Code: ___________

Phone: _____________________________ Ext: ________ Fax: ____

Relationship to applicant: ________________________ How long have you known the applicant? ___________

How many contacts do you have with the applicant per month? ____

Referral discussed with: ☐ Applicant ☐ Family ☐ Doctor (s)

If applicant is unaware of referral, please explain: ____

Reason for referral: ____

____

Applicant Personal Information

Current Living Arrangements

☐ On my own ☐ Spouse / Partner ☐ Parents ☐ Children ☐ Friends ☐ Supportive Housing

☐ Private Apt/House ☐ Hostel / Shelter ☐ Boarding Home ☐ Shared Accommodation

Other: ____

Income Information

☐ Employment ☐ Employment Insurance (EI) ☐ Family ☐ Canadian Pension Plan (CPP) ☐ Disability Assistance

☐ Ontario Disability Support Program (ODSP) ☐ Social Assistance (Ontario Works) ☐ No source of income at this time

☐ Other: ____

What Extra Supports Might You Need?

	Independent	Need some assistance	Always need assistance
Self Care			
Household chores			
Cooking			
Handling finances			
Using TTC			
Improving employability and career possibilities			
Adding structure to my day			
Self managing medication			
Getting to appointments			
Avoiding unsafe situations			
Understanding English- Reading and writing			
Managing personal problems			
Socializing			
Wellness Recovery Action Planning (WRAP)			
Self advocacy-knowing my rights			

Challenging Issues – Have you ever struggled with?

	Yes	No	Date	Circumstances/Frequency/Severity
Suicide – threats				
Suicide attempts				
Self-abuse / Self harm				
Aggression – physical				
Aggression –verbal				
Mishandling Fire				
Lack of attention while smoking				
Assault – Sexual				
Assault – Physical				
Abuse of Property				
Sexual Acting Out				
Drug/Alcohol use				
Problems with Anger				
Issues with collecting things				

Applicant's Strengths and Resources

How have you gotten through the tough times in your life? ____

____

What supports have you found useful? What do you wish had happened? ______________________________

____

What have these experiences taught you? ____

____

Who do you go to for help in times of trouble? ____

____

Legal Involvement

Do you have any current or past legal involvement? (i.e. currently facing charges, on probation or parole, in custody, convictions, etc.)

☐ Yes ☐ No ☐ Unknown

If yes, please indicate dates, types of involvement and outcome:

Present: ____

Past: ____

Conditions/restrictions resulting from legal involvement: ______________________________________

Applicant's Mental Health Status

How long have you been challenged by mental health issues (i.e., length of time)? ____________________

Have you ever been formally given a mental health diagnosis? ☐ Yes ☐ No ☐ Don't know

If yes, what was/is the primary diagnosis? ____

Are you struggling with any other mental health issues? __________________________________

Are you struggling with any issues related to substance use (such as drugs or alcohol)? __________________

Are you struggling with any intellectual disability? _______________________________________

Have you been to a hospital emergency department in the past 2 years for mental health reasons? ☐ Yes ☐ No

If yes, how many times have you needed to use emergency room services in the past 2 years? ______________

Have you been hospitalized due to mental health issues in the past 2 years? ☐ Yes ☐ No

If you answered 'Yes' to the above question, please provide the following information:

Admission Date (dd/mm/yy)	Discharge Date (dd/mm/yy)	Name of Hospital	Reason for Hospitalization

Psychiatrist Name: ____

Address: ____

Telephone: ________________________ Ext. _____ Hospital Affiliation: ______________________________

Frequency of appointments: ____________________

What psychiatric medications are you currently being prescribed?

Name of Medication	Dosage and Frequency	Prescribed by

Applicant's Physical Health Status

Do you have other physical health conditions or challenges (Example: allergies, diabetes, hearing impairment)? ☐ Yes ☐ No

If yes, please describe: ____

____

Physician/G.P./Family Doctor: First Name: ______________________________ Last Name: ________________________________

Address: ____

Telephone: ____________________________ Ext. _____ Hospital Affiliation: ____________________________________

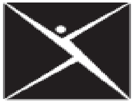
What non-psychiatric medications and alternative medicines are you currently being prescribed?

Name of Medication	Dosage and Frequency	Prescribed by

Return Completed Applications to:

To apply for programs and services **West of Yonge Street** in Toronto please forward the referral package, consent forms and supporting documents to: **Canadian Mental Health Association** **Lawrence Ave Site** **Attn: Intake Coordinator** **700 Lawrence Ave West** **Suite 480** **Toronto ON M6A 3B4** **Tel: (416) 789-6880** **Fax: (416) 789- 6895** **Email: tgordon@cmha-toronto.net**	To apply for programs and services **East of Yonge Street** in Toronto please forward the referral package, consent forms and supporting documents to: **Canadian Mental Health Association** **Markham Rd Site** **Attn: Intake Coordinator** **1200 Markham Rd** **Suite 500** **Scarborough ON M1H 3C3** **Tel: (416) 289-6285 ext. 243** **Fax: (416) 289-4306** **Email: tmckay@cmha-toronto.net**	Do not use this form to apply for Case Management and ACT Services in **Scarborough and North York** **Contact ACCESS 1:** **1-888-640-1934**

Revised 21-Dec-2009



CONSENT TO DISCLOSURE and COLLECTION OF PERSONAL HEALTH INFORMATION

I, ____D.O.B____________________
(Name)

of ____
(Address)

authorize the disclosure and collection of personal health and mental health information between

____ and
(Name of person / agency disclosing information)

The Canadian Mental Health Association – Toronto Branch___
(Name of person / agency requesting information)

With regards to ____
(Name) (Address)

All information obtained will be kept confidential between the parties specified above.

I understand I may withdraw this authorization at any time in writing. This release will be effective for 12 months from the date it is signed.

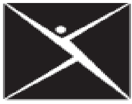
_____________________________ Signature of Person

_____________________________ Signature of Witness

_____________________________ Please Print Name

_____________________________ Please Print Name

_______________________ Date



CONSENT TO DISCLOSURE and COLLECTION OF PERSONAL HEALTH INFORMATION

I, ____D.O.B__________________
(Name)

of ____
(Address)

authorize the disclosure and collection of personal health and mental health information between

____ and
(Name of hospital disclosing information)

The Canadian Mental Health Association – Toronto Branch___
(Name of person / agency requesting information)

With regards to ____
(Name) (Address)

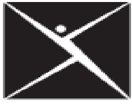
All information obtained will be kept confidential between the parties specified above.

I understand I may withdraw this authorization at any time in writing. This release will be effective for 12 months from the date it is signed.

____________________________ ______________________________
Signature of Person Signature of Witness

____________________________ ______________________________
Please Print Name Please Print Name

____
Date



CONSENT TO DISCLOSURE and COLLECTION OF PERSONAL HEALTH INFORMATION

I, ____D.O.B___________________
(Name)

of ____
(Address)

authorize the disclosure and collection of personal health and mental health information between

____ and
(Name of treating family doctor or psychiatrist disclosing information)

The Canadian Mental Health Association – Toronto Branch___
(Name of person / agency requesting information)

With regards to ____
(Name) (Address)

All information obtained will be kept confidential between the parties specified above.

I understand I may withdraw this authorization at any time in writing. This release will be effective for 12 months from the date it is signed.

____________________________	______________________________
Signature of Person	Signature of Witness
____________________________	______________________________
Please Print Name	Please Print Name

____
Date