



**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

living working belonging

**Living, Working, Belonging....this is our goal at CMHA Toronto for all our clients.
Every day our teams provide the supports and services that our clients need so that they can:
Live in the community, in clean, safe affordable accommodation
Work in the community, in paid employment or volunteer activities
Belong in the community, as engaged, valued and contributing members**

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.

<i>Program</i>	<i>Catchment Area (to apply for service using this form)</i>	<i>Criteria for Referral</i>	<i>How to apply</i>
<input type="checkbox"/> <p>Case Management-West (West of Yonge St in TO)</p> <p>Service also available in French (Passages Program) AND Italian (Breakthrough Program)</p>	<ul style="list-style-type: none"> • East to Yonge Street • West to Hwy 427 • North to Eglinton • South to the Lake 	<ul style="list-style-type: none"> • 16 years of age and older • Diagnosed as having a serious mental illness • Needing assistance with activities of daily living, symptom management, socialization, education, employment, housing, etc. • Willing to accept service 	<p>-Complete this form if you reside within the outlined catchment area</p> <p>-Do not use this form if you reside in Scarborough or North York</p> <p>Applicants living in Scarborough and North York must apply for service with ACCESS 1 by contacting: 1-888-640-1934</p>
<input type="checkbox"/> <p>Case Management-East (East of Yonge St in TO)</p> <p>RAP (Rehabilitation Action Program) available in Tamil, Somali, Dari, Pashto, and English where culture is a barrier to participating in mental health services</p>	<ul style="list-style-type: none"> • East to Victoria Park • West to Yonge Street • North to Eglinton • South to the Lake <p>RAP (Rehabilitation Action Program) available only in Scarborough</p>	<ul style="list-style-type: none"> • 16 years of age and older • Diagnosed as having a serious mental illness • 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 	<p>-Complete this form if you reside within the outlined catchment area</p> <p>-Do not use this form if you reside in Scarborough or North York</p> <p>Applicants living in Scarborough and North York must apply for service with ACCESS 1 by contacting: 1-888-640-1934</p>
<input type="checkbox"/> <p>Transitional Youth Program</p>	<ul style="list-style-type: none"> • East to Port Union Rd • West to Islington • North to Steeles • South to the Lake 	<ul style="list-style-type: none"> • Between 16 and 22 years of age • Diagnosed as having a serious mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder) • Willing to accept service 	<p>-Complete this form if you reside within the outlined catchment area</p>

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.

<i>Program</i>	<i>Catchment Area (to apply for service using this form)</i>	<i>Criteria for Referral</i>	<i>How to apply</i>
West Metro ACT Team (Allen Rd/Arlington Ave- Humber River) (Steeles Ave-St.Clair Ave)	Do not use this form to apply for ACT Service	<ul style="list-style-type: none"> • 16 years of age and older • Diagnosed as having a serious 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	<ul style="list-style-type: none"> • 16 years of age and older • Diagnosed as having a serious 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

<i>Program</i>	<i>Catchment Area (to apply for service using this form)</i>	<i>Criteria for Referral</i>	<i>How to apply</i>
Mental Health and Justice Programs	Do not use this form To apply for MHJ Services	<ul style="list-style-type: none"> • 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 	<p>-MHJ Long Term Housing and Case Management Services Unit Registry: 416-757-6454</p> <p>-MHJ Short Term (Safe Beds) Unit Registry: 416-248-4174</p> <p>-MHJ Prevention Program (Scarborough): 416-458-9466</p> <p>-Court Support and Diversion Metro West Court: 416-745-5775 Metro East Court: 416-285-4177</p>
Mood and Psychosis Early Intervention Program (MOD)	Do not use this form to apply for EI Services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Intensive Case Management Services for people who are on CTO's living in Toronto 	-Referrals are accepted from CAMH CTO coordinators and physicians

Other Specialized Programs / Services (Cont.)

<i>Program</i>	<i>Catchment Area (to apply for service using this form)</i>	<i>Criteria for Referral</i>	<i>How to apply</i>
Housing Services	Do not use this form to apply for Housing Services	<ul style="list-style-type: none"> 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: www.TOsupportivehousing.ca
Employment Services	Do not use this form to apply for Employment Services	<ul style="list-style-type: none"> 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 315 youth ext 302

Social Opportunities

<i>Program</i>	<i>Catchment Area (to apply for service using this form)</i>	<i>Criteria for Referral</i>	<i>How to apply</i>
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Women 16 years of age and older Diagnosed as having a serious mental illness 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	<ul style="list-style-type: none"> 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. _____ Fax: _____

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:

<p>To apply for programs and services West of Yonge Street in Toronto please forward the referral package, consent forms and supporting documents to:</p> <p>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: Westintake@cmha-toronto.net</p>	<p>To apply for programs and services East of Yonge Street in Toronto please forward the referral package, consent forms and supporting documents to:</p> <p>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: Eastintake@cmha-toronto.net</p>	<p>Do not use this form to apply for Case Management and ACT Services in Scarborough and North York</p> <p>Contact ACCESS 1: 1-888-640-1934 www.access1.ca</p>
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Revised 14-Feb-11



CONSENT TO DISCLOSURE AND COLLECTION OF PERSONAL HEALTH INFORMATION

I, _____
(Name of client or Substitute Decision Maker "SDM")

Of _____
(Address)

Authorize the disclosure and collection of personal health information between:

_____ and
(Name of person/agency disclosing information)

_____ Canadian Mental Health Association Toronto Branch
(Name of person / agency requesting information)

With regards to:

_____ *(Name of client)* _____ *(Date of Birth)*

_____ *(Address)*

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

I understand that I may withdraw this authorization at any time in writing.

Name of client/SDM – please print

Name of witness – please print

Signature of client/SDM

Signature of witness

Date



CONSENT TO DISCLOSURE AND COLLECTION OF PERSONAL HEALTH INFORMATION

I, _____
(Name of client or Substitute Decision Maker "SDM")

Of _____
(Address)

Authorize the disclosure and collection of personal health information between:

_____ and
(Name of hospital / doctor disclosing information)

_____ Canadian Mental Health Association Toronto Branch
(Name of person / agency requesting information)

With regards to:

_____ *(Name of client)* _____ *(Date of Birth)*

_____ *(Address)*

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

I understand that I may withdraw this authorization at any time in writing.

Name of client/SDM – please print

Name of witness – please print

Signature of client/SDM

Signature of witness

Date