



Post-Incarceration Housing Program

REFERRAL FORM

Program Objective

To support individuals, with mental health concerns who have recent/current involvement in the criminal justice system, to find and maintain appropriate housing and engage in community services /supports.

Eligibility Criteria

CHECK ALL THAT APPLY

- Homeless or at risk of becoming homeless - How long? _____ Years _____ Months
- Current willingness to actively take part in own housing search (**PIH does NOT have stock housing available**)
- Mental health diagnosis/issues: _____
- Criminal justice involvement

Applicant Information

Last Name:		First Name:		Middle Initial:				
DOB (mm/dd/Year):			Gender:					
Preferred Language:			Citizenship Status:					
Income Source:		<input type="checkbox"/> ODSP	<input type="checkbox"/> OW	<input type="checkbox"/> CPP	<input type="checkbox"/> Other			
Current Living Situation: (CHECK THE BEST DESCRIPTION OF CURRENT LIVING SITUATION)								
<input type="checkbox"/> Shelter	<input type="checkbox"/> Correctional Centre	<input type="checkbox"/> Street	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Housed	<input type="checkbox"/> Other			
Shelter Name:	Centre Name:	Area:	Address:	Address:				
	Release Date:							
Telephone Number (applicant):			Alternate Contact Person (Name and Number):					
Does the applicant have any physical health issues?								
Does the applicant have ID?		<input type="checkbox"/> Health card	<input type="checkbox"/> Driver's license	<input type="checkbox"/> Passport				
Please check and attach COPY of ID.		#: _____	#: _____	#: _____				
Does applicant have substance use issues?		Substances Used:		How long/frequency of use:				
Criminal Justice Involvement: PLEASE CHECK AND FILL IN ALL THAT APPLY								
Class 1	Year	Convict (Y/N)	Class 2	Year	Convict (Y/N)	Class 3 & Drug Charges	Year	Convict (Y/N)
<input type="checkbox"/> Failure to Appear			<input type="checkbox"/> Simple Assault			<input type="checkbox"/> Assault Domestic		
<input type="checkbox"/> Failure to Comply			<input type="checkbox"/> Criminal Harassment			<input type="checkbox"/> Assault bodily harm		
<input type="checkbox"/> Theft Under			<input type="checkbox"/> Assault Peace			<input type="checkbox"/> Aggravated		

			Officer			Assault		
<input type="radio"/> Mischief Under			<input type="radio"/> Indecent Act			<input type="radio"/> Carry Concealed Weapon		
<input type="radio"/> Fraud Under			<input type="radio"/> Break and Enter			<input type="radio"/> Assault with a weapon		
<input type="radio"/> Harassing Phone Call			<input type="radio"/> Resisting Arrest			<input type="radio"/> Sexual Assault		
<input type="radio"/> Cause Disturbance			<input type="radio"/> Public Mischief/to property			<input type="radio"/> Possession with purpose of trafficking		
<input type="radio"/> Failure to leave Premises			<input type="radio"/> Uttering threats/threaten death			<input type="radio"/> Possession of cocaine/narcotics		
<input type="radio"/> Other:			<input type="radio"/> Arson			<input type="radio"/> Possession of marijuana/substance		

Applicant Supports

Support Type	YES	NO	Name	Office #	Cell #
Case Manager					
Housing Worker					
Probation/Parole Officer					
Court Support Worker					
Psychiatrist					
GP					

Housing Information

Where does applicant want to live?	<input type="radio"/> Downtown	<input type="radio"/> North York	<input type="radio"/> Etobicoke	<input type="radio"/> Scarborough
Is applicant on Access Point housing waitlist?	<input type="radio"/> Yes	<input type="radio"/> No	Access Point ID #:	
Is applicant on Housing Connection waitlist?	<input type="radio"/> Yes	<input type="radio"/> No	TAL #:	
What is applicant preferred housing type?	<input type="radio"/> Independent	<input type="radio"/> Shared	<input type="radio"/> Boarding	<input type="radio"/> Shelter
Has applicant lived in subsidized Housing?	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, Date:	

Referral Source

Referring Worker Name:	
Agency:	
Program:	
Position:	
Office Number:	
Cell Number:	
Email:	

How to Refer

Please fax completed PIH Referral form, signed consent form and if possible copy of applicant's ID to the Canadian Mental Health Association, Toronto Branch.

FAX: 416-289-6843 PHONE: 416-789-7957 ext. 3800

CMHA Post-Incarceration Program is offered in partnership with City of Toronto: Streets to Homes



Canadian Mental
Health Association
Toronto

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)

(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

