Canadian Mental Health Association Toronto

Post-Incarceration Housing Program

REFERRAL FORM

Clear 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:	☐ ODSP	☐ OW	☐ CPP	☐ Other	
Current Living Situation: **(CHECK THE BEST DESCRIPTION OF CURRENT LIVING SITUATION)**					
☐ Shelter	☐ Correctional Centre	☐ Street	☐ Family/Friend	☐ Housed	☐ Other
Shelter Name:	Centre Name: Release Date:	Area:	Address:	Address:	
Telephone Number (applicant):			Alternate Contact Person (Name and Number):		
Does the applicant have any physical health issues?					
Does the applicant have ID?	☐ Health card		☐ Driver's license	☐ 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)**
☐ Failure to Appear			☐ Simple Assault			☐ Assault Domestic		
☐ Failure to Comply			☐ Criminal Harassment			☐ Assault bodily harm		
☐ Theft Under			☐ Assault Pease			☐ Aggravated		

			Officer			Assault		
☐ Mischief Under			☐ Indecent Act			☐ Carry Concealed Weapon		
☐ Fraud Under			☐ Break and Enter			☐ Assault with a weapon		
☐ Harassing Phone Call			☐ Resisting Arrest			☐ Sexual Assault		
☐ Cause Disturbance			☐ Public Mischief/to property			☐ Possession with purpose of trafficking		
☐ Failure to leave Premises			☐ Uttering threats/threaten death			☐ Possession of cocaine/narcotics		
☐ Other:			☐ Arson			☐ 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?	☐ Downtown	☐ North York	☐ Etobicoke	☐ Scarborough
Is applicant on Access Point housing` waitlist?	☐ Yes	☐ No	Access Point ID	#:
Is applicant on Housing Connection waitlist?	☐ Yes	☐ No	TAL	#:
What is applicant preferred housing type?	☐ Independent	☐ Shared	☐ Boarding	☐ Shelter
Has applicant lived in subsidized Housing?	☐ Yes	☐ No	If Yes, Date:	

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

How to Refer

1. Referrals **must** be sent in with a signed consent.
2. Referrals will only be accepted **within 1 month** of release/discharge from a hospital or detention centre.
3. **We do not keep a wait list.**

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. 3631

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