Transitional Youth Program
Application for Service

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

Transitional Youth Program

The Transitional Youth Program assists youth who have been diagnosed with schizophrenia or a mood disorder and are beginning to deal with the symptoms of the illness and its impact on their lives. It is an intensive clinical support program which provides services in our office and in the community, offering both therapeutic and case management interventions. The goal of the program is to assist the youth to regain and maintain age appropriate milestones and minimize the disruption that mental illness can have on their lives. TYP works closely with the clients, and their families and supports to assist them in understanding and coping with the illness. The key focuses of the program are education, employment and socialization with peers.

Who are TYP Services for?

- Individuals between the ages of 16 and 24 years of age
- Diagnosed as having a serious mental illness including Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder, Major Depressive Disorder
- Individuals currently receiving treatment from a community psychiatrist
- Services are available to residents of the City of Toronto that are living east of Islington Avenue

To apply for programs and services
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) 789-7957 ext. 3800
Fax: (416) 289-6843
Email: Eastdecisionsupport@cmha.org

A participant in the United Way

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: ____

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				

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

CANADIAN MENTAL
HEALTH ASSOCIATION

ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

Toronto Branch

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

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

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