Sept 9, 2008 Edition

Tel: (416) 757- MHJI (6454) Fax: (416) 916-2383

Mental Health & Justice Supportive Housing - Application Form

WELCOME!

The Toronto Mental Health & Justice Supportive Housing Agency group consists of four (4) LEAD agencies: CMHA, COTA Health, Houselink Community Homes, and LOFT Community Services, as well as five (5) Partner agencies: Toronto North Support Services, Reconnect Mental Health Services, CRCT, Across Boundaries, and North York General Hospital. This group has been established to provide streamlined access to self contained supportive housing, as funded by the Ministry of Health and Long-Term Care, for adults *(16 years of age or older)* in the City of Toronto living with severe and persistent mental illness and who have current involvement with the criminal justice system *(including Pre-Charge Diversion services)*.

With this application form you will be considered for a self-contained apartment unit within Etobicoke, North York, Scarborough and Downtown Toronto. The purpose of the questions is to help us learn what kind of housing you want and need, as well as what kind of supports you want and need to live safely in the community. Please PRINT all information in ink. We ask you read and understand the Declaration and Consent on page 13 and sign the form.

The confidentiality of the information you provide will be respected. If another person is acting as Referrer, they must also sign on page 13.

The completed form should be faxed to LOFT at **(416) 916-2383.** You will be contacted within one (1) business day to confirm the receipt of your fax.

Note: Specific information of the supportive housing options provided by each participating agency is available upon request.

APPLICANT INFORMATION

First Name: ______________________ Initial: ________

Last Name: ______________________

Street Address: ______________________

Apt. No.: ____________ Telephone Number: ______________

City: ______________ Province: ______ Postal Code: __________

Current Residence Type:

☐ Rooming/Boarding Home ☐ Private House/Apartment/Condo

☐ Supportive Housing – Congregate living ☐ Supportive Housing - Group Home

☐ Hostel/Shelter ☐ Municipal Non-Profit Housing

☐ Other__________________

Current Living Arrangements:

☐ Self ☐ Spouse/partner ☐ Spouse/partner & others ☐ Children

☐ Parents ☐ Relatives ☐ Non-Relatives ☐ Other__________

Age: ______ Date of Birth: ______________
Day / Month / Year

Gender: ☐ Male ☐ Female ☐ Transgender

STATUS IN CANADA: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Refugee Claimant

Aboriginal origin: ☐ Aboriginal ☐ Non-Aboriginal ☐ Unknown

Do you speak English? ☐ Yes ☐ No ☐ Some

What is your preferred language? ______________________

Do you have an Ontario Health Card? ☐ Yes ☐ No

REFERRING AGENCY/WORKER INFORMATION

What program/service is the applicant being referred from? *(please check appropriate box)*

COURT SUPPORT:

☐ 102 ☐ OCH ☐ College Park ☐ Scarborough
☐ North York ☐ West ☐ Other (please specify): ________________

CRISIS PREVENTION SERVICES:

☐ Downtown ☐ Etobicoke ☐ North York ☐ Scarborough

MENTAL HEALTH & JUSTICE CRISIS BEDS:

☐ Downtown ☐ Etobicoke ☐ North York ☐ Scarborough

MENTAL HEALTH & JUSTICE INTESIVE CASE MANAGEMENT:

☐ Transitional Age Youth ☐ Dual Diagnosis ☐ Court Case Management

HOSPITAL FORENSIC UNITS:

☐ CAMH Law & Mental Health Program ☐ Whitby Forensic Unit

OTHER (Please Specify): ____

Referring Agency/Worker:

First Name: ______________________ Last Name: ___________________________

Agency: ____

Address: ____

Tel. _________________________ ext. ____________ Fax: ____________________

Relationship To Applicant: ____

How Long Have You Known The Applicant? ____

How Many Contacts Do You Have With The Applicant Per Month? _______________________

Do You Intend To Remain Involved With The Applicant If He/She Secures Housing?

☐ YES ☐ NO

If YES, Please Describe The Level of Involvement That You Intend To Maintain:

____

____

____

____

WHAT HOUSING DOES THE APPLICANT WANT?

(Please select only one area)

☐ North York – West of Victoria Park Avenue, North of Eglinton Avenue, East of Humber River, South of Steeles Avenue

☐ Scarborough – East of Victoria Park Avenue, South of Steeles Avenue, West of Port Union Road

☐ Downtown – East of Humber River, South of Eglinton Avenue, West of Victoria Park Avenue

☐ Etobicoke – West of Humber River, South of Steeles Avenue

There is a limited amount of supportive housing units available for families. Does this apply to you?

☐ Yes ☐ No

If yes, please provide the following information about them:

Name	Relationship to you	Date of Birth Day/Month/Year	Gender (M/F)	Monthly Income

This form will be submitted to the 4 Lead Agencies that have the supportive housing that most closely matches your needs and preferences. However, you can still list particular agencies that you want your application sent to. Agencies should be listed in order of preference - i.e., with your first choice as #1, etc. If there is a particular address you want to be considered for, you may indicate it as well.

Agency	Housing Address (Optional)
1.	
2.	
3.	
4.	

If there is a particular agency or address that you would prefer ***not*** to be considered for, please indicate so:

____

Do you require housing suitable for a physically disabled person? ☐ Yes ☐ No

If yes, please explain: ____________________________________

When do you require housing? ______________________________
Date

APPLICANT'S HOUSING HISTORY

Please list your housing history for the past 3 years:

Address:____
Type of Housing: ____________________________________
Landlord/Agency Name: ____________________ Phone# ____________
Date moved in: ________________Date moved out:________________
Reason for leaving: __________________________________

Address:____
Type of Housing: ____________________________________
Landlord/Agency Name: ____________________ Phone# ____________
Date moved in: ________________ Date moved out:________________
Reason for leaving: __________________________________

Address:____
Type of Housing: ____________________________________
Landlord/Agency Name: ____________________ Phone# ____________
Date moved in: ________________Date moved out:________________
Reason for leaving: __________________________________

Address:____
Type of Housing: ____________________________________
Landlord/Agency Name: ____________________ Phone# ____________
Date moved in: ________________Date moved out:________________
Reason for leaving: __________________________________

Other comments relating to housing history:

____

____

____

____

____

APPLICANT'S HEALTH STATUS

How long have you been experiencing mental health difficulties (i.e., length of time)?

____

____

Have you been diagnosed with a mental illness? ☐ Yes ☐ No ☐ Don't know

If Yes, what was the diagnosis? ______________________________

Have you ever gone to a Hospital Emergency Room due to mental health difficulties?

☐ Yes ☐ No

If Yes, how many times have you gone to an Emergency Room in the past two years? ________

Have you been hospitalized due to mental health challenges in the last two years?

☐ Yes ☐ No

If Yes, please provide an estimate of the total number of days that you have spent in Hospital, due to mental health difficulties, within the past two years:

____

Estimated Number of Days

Do you have a concurrent disorder? A concurrent disorder is a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder.

☐ Yes ☐ No ☐ Don't know

If yes, please explain: ______________________________

____

Do you have a dual diagnosis? A dual diagnosis is a situation in which a person experiences an intellectual disability and has mental health needs.

☐ Yes ☐ No ☐ Don't know

If yes, please explain: ______________________________

____

Do you have other physical health conditions/problems (including allergies) or disabilities?

☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

____

APPLICANT'S PRESENTING ISSUES

Check All That Apply:

☐ Threat to others/attempted suicide ☐ Specific Symptoms of Serious Mental Health Illness

☐ Financial ☐ Legal ☐ Problems with Relationships ☐ Education ☐ Housing

☐ Activities of daily living skills ☐ Problems with substance abuse/addictions

☐ Occupational/Employment/Vocational ☐ Other ___________________________________

OTHER RELEVANT INFORMATION ABOUT THE APPLICANT

We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of these questions below will ***NOT*** exclude you from service. If you have any history of the following, please comment (e.g., when, how often, how severe):

Self-harm or suicide threats or attempts: ____

____

____

Substance use or treatment: ____

____

____

Aggression or violence (verbal, physical, sexual): _____________________________________

____

____

Destruction of Property (including fire setting): _______________________________________

____

____

As you are aware, this housing is for individuals who not only have mental health difficulties, but who also have current involvement with the criminal justice system. We ask the following questions to clarify the nature of your involvement with the criminal justice system. Again, answering any of these questions below will ***NOT*** exclude you from service. We know these may be sensitive questions and we appreciate you answering them:

Please provide a brief account of your current involvement with the criminal justice system.

____

____

____

____

____

____

Please indicate all pending and previous charges

Pending/Previous Charges – *Class 1*

	Charge	**Date(s)**
	Mischief Under	
	Fail to Appear	
	Fail to Comply	
	Harassing phone call	
	Fail to leave premises	
	Cause Disturbance	
	Communicate for the purpose	
	Other:	

Pending/Previous Charges – *Class 2*

Counts	**Charge**	**Date(s)**
	Uttering/Threats/Threaten Death	
	Public Mischief/To Property	
	Resisting Arrest	
	Simple Assault	
	Assault Peace Officer	
	Break & Enter	
	Criminal Harassment	
	Indecent Act	
	Obstruct Police Officer	
	Other:	

Pending/Previous Charges – *Class 3*

Counts	**Charge**	**Date(s)**
	Assault with a weapon	
	Weapon dangerous	
	Carry concealed weapon	
	Assault bodily harm	
	Sexual Assault	
	Aggravated assault	
	Assault (domestic)	
	Other:	

Drug Charges

Counts	**Charge**	**Date(s)**
	Possession of Marijuana/Substance	
	Possession of Cocaine/ Narcotics	
	Possession for the purpose of trafficking	

What is your present status within the justice system (please check all that apply):

☐ Released on bail ☐ Awaiting trial ☐ Awaiting sentencing

☐ Charges withdrawn ☐ Stay of proceedings ☐ Peace Bond

☐ Absolute discharge ☐ Conditional Discharge ☐ Time served

☐ Suspended Sentence ☐ Conditional Sentence ☐ Custodial Sentence

☐ Probation (please specify the length of time remaining: ____________________)

☐ Other (please explain): ____

____

WHAT SUPPORT DOES THE APPLICANT NEED?

What kind of support do you think you need?

☐ 24-hour ☐ Daily ☐ Weekly ☐ Other (specify): _______________

Do you need support with any of the following?

	A Lot	Some	None
Household Chores			
Preparing Meals			
Shopping			
Handling Finances			
Using Transportation			
Relating to People			
Managing Anger			
Dealing With Drug or Alcohol Dependency			
Employment			
Education/Training			

Other Areas (please describe):

____

____

____

____

WHAT SUPPORT DOES THE APPLICANT HAVE?

Do you have a psychiatrist? ☐ Yes ☐ No

If Yes, please provide his/her contact Information:

Name: ____

Telephone Number: ______________________________

Do you have a physician (e.g., GP, family doctor, walk-in clinic doctor)? ☐ Yes ☐ No

If Yes, please provide his/her contact Information:

Name: ____

Telephone Number: ______________________________

Are you presently working with any other service providers? ☐ Yes ☐ No

If Yes, please provide the following information on each service provider with whom you are working:

Agency	Name/Contact Person	Services Received	Telephone Number

Please describe any other supports that you may have in your life (e.g., family, friends, faith community, cultural groups/community, other community supports):

INCOME INFORMATION

Most participating agencies provide rent-geared-to-income and other subsidized housing and have to determine income eligibility. Please list the sources of income that you currently receive (gross amounts – i.e., before deductions).

	Monthly Amount
☐ No Source of Income	
☐ Social Assistance (Ontario Works)	
☐ Disability Assistance	
☐ Ontario Disability Supp. Prog. *(ODSP)*	
☐ Canadian Pension Plan *(CPP)*	
☐ Employment	
☐ Employment Insurance *(EI)*	
☐ Family	
☐ Other: ______________________________	
TOTAL:	

☐ Other Personal Assets:

ASSET TYPE	TOTAL VALUE

If you have applied for one of the above sources, but are not yet receiving it, please provide

details: ____

____

____

____

YOUR DECLARATION AND CONSENT

This is your agreement with us. We promise that your confidentiality will be respected. You agree to what is set out below. Please read it carefully before signing.

I have done my best to ensure the information provided in this application is correct.

I understand that in order to assess my support needs, the Network Office and/or the 4 Lead Agencies and/or the 5 Partner agencies may contact and share information with the Workers (if any) listed on page 10 of this application and with the Referring agency who signs below. I give my permission for this to occur.

Applicant's Signature: ______________________________ **Date:** ____________________

REFERRER'S STATEMENT

The Referrer must also sign below.

To the best of my knowledge, the information contained in this application is correct. I have known the applicant for the following length of time:

____

Referrer's Signature: ____________________________ **Date:** ______________________

Name (PRINT): _______________________________ Position: _____________________

Agency: __________________________________ Tel. No.: ________________________