

**Reconnect Mental Health Services
Common Application Form**

A. HOW CAN WE CONTACT YOU?

Applicant:

First Name: _____

Last Name: _____

Street Address: _____

City: _____ Province: _____ Postal code: _____

Apt. #: _____ Entry code: _____

Telephone #: (_____) _____ - _____ Extension: _____

Other means of contact: _____

Major intersection: _____

If you do not have a phone or are otherwise difficult to reach, is there someone with whom you are in regular contact that we can call in order to reach you?

Name: _____

Telephone #: (_____) _____ - _____ Extension: _____

Relationship or organization: _____

Can a message be left at the phone number provided? Yes No

B. REFERRAL SOURCE INFORMATION (Please complete if not a self-referral):

Name: _____

Agency: _____

Position: _____

Telephone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Street Address: _____ Apt./Suite #: _____

City: _____ Province: _____ Postal code: _____

Relationship to applicant: _____

Do you intend to remain involved with the applicant if he/she secures services from Reconnect Mental Health Services? Yes No

If Yes, please describe the level of involvement that you intend to maintain:

Is the client aware of this referral? Yes No

Please note any collateral information would be helpful to send as it can expedite the process.

C. INFORMATION TO HELP US DIRECT YOUR APPLICATION

Date of Birth (mm/dd/yy): ____/____/____

Gender: Male Female Transgender Transsexual Other _____

Do you speak English: Yes No Some

What is your preferred language?

English French Other _____

Who do you presently live with? Please check all boxes that apply:

Self Spouse/partner Spouse/partner & others
 Parents Relatives Non-Relatives
 Children (Age/Sex) _____

Are you currently homeless or at risk of becoming homeless?

Yes No Somewhat _____

What type of housing do you presently live in?

Approved Homes & Homes for Special Care
 General Hospital
 Correctional/Probationary Facility
 Domiciliary Hospital
 Private House/Apt. - Owned/Market Rent
 Psychiatric Hospital

- Private House/Apt. - Other/Subsidized
- Rooming/Boarding House
- Retirement Home/Senior's Residence
- Other Specialty Hospital
- Supportive Housing – Congregate Living
- No fixed address
- Hostel/Shelter
- Private Non-Profit Housing
- Long-Term Care Facility/Nursing Home
- Municipal Non-Profit Housing
- Supportive Housing – Assisted Living (Group Homes)
- Other _____

What type of support do you receive?

- Independent (no support needed for tasks such as cooking, cleaning, paying bills, etc.)
- Assisted/Supported (some support needed from family or staff to take care of home)
- Supervised non-facility (require significant assistance and coaching)
- Supervised facility (hospital, correctional facility, long term care)
- Prefer not to answer
- Unknown

What is your primary source of income?

- ODSP
- Social Assistance (e.g., Ontario Works)
- Employment
- Employment Insurance
- Pension (CPP, workplace pension)
- Family
- Disability Assistance (private insurance plan, long term disability)
- No Source of Income
- Other _____

Are you currently involved with the criminal justice system? (Please note, this will not affect your ability to receive service. It is to help us better direct your application)

- Yes No I don't know

If yes, please indicate dates, types of involvement and outcome:

D. ADDITIONAL INFORMATION ABOUT YOU (Please note, this will not affect your ability to receive service. It is to help us better direct your application)

Marital status

- Domestic Partner
- Married
- Separated
- Separated Domestic Partner
- Single
- Widowed
- Widowed Domestic Partner
- Prefer not to answer

Citizenship

- Canadian Citizen
- Refugee Claimant
- Landed Immigrant

Culture

- Aboriginal
- African
- American
- Australian/New Zealander/Pacific Islander
- Canadian
- Canadian-French
- Caribbean
- East and South East Asian
- Eastern European
- European
- Latin/Central/South American
- South Asian
- West Asian or Arab
- Prefer not to answer
- Other: _____

What is your highest level of education?

- No formal schooling
- Some elementary/junior high school
- Elementary/junior high school
- Some secondary/high school
- Secondary/high school
- Some college/university
- College/University
- Prefer not to answer

Are you currently in school? Yes No

- Not in school
- Vocational/training centre
- Elementary/junior high school

- Adult education
- Secondary/high school
- Community college
- Trade school
- University
- Prefer not to answer

Currently employed? Yes No

Employment type

- Alternative businesses
- Assisted/supportive
- Causal/sporadic
- Independent/competitive
- No employment – other activity
- No employment of any kind
- Non-paid work experience (ex. volunteer)
- Sheltered workshop
- Prefer not to answer

E. HEALTH INFORMATION

Do you struggle with mental health issues? Yes No Unknown

Have you been diagnosed with a mental health issue? Yes No Unknown

If yes, what was the diagnosis?

Primary diagnosis: _____ **Secondary diagnosis:** _____

Describe your symptoms (e.g., delusions, hallucinations, social withdrawal):

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

What was the age of onset of mental illness? _____

What was the age of first psychiatric hospitalization/diagnosis? _____

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

- Yes No Unknown

Name of hospital

Date of Admission

Estimated # of days in hospital

Reason for hospitalization:

Are you in hospital now due to mental health issues? Yes No

Are you currently on a Community Treatment Order (CTO) order? Yes No

Do you have a substitute decision maker (SDM)? Yes No

Do you have a psychiatrist? Yes No

If Yes, please provide his/her contact information:

Name: _____

Telephone #: (_____) _____ - _____

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 #: (_____) _____ - _____

Do you have any other health conditions, problems (including allergies) or disabilities?

Yes No Unknown

If yes, please describe:

Do you have a concurrent disorder? A concurrent disorder is when a person experiences a mental health concern and a substance use disorder.

Yes No Unknown

Do you have a dual diagnosis? A dual diagnosis is when a person experiences a mental health concern and a developmental disability.

Yes No Unknown

F. APPLICANT'S SUPPORT NEEDS:

Presenting Issues:

- Specific symptoms of serious mental health illness
- Activities of daily living
- Finances
- Legal
- Housing
- Relationships
- Educational opportunities
- Occupational/employment/vocational
- Substance abuse/addictions Issues
- Attempted suicide
- Victim of physical/sexual abuse
- Threat to others
- Other: _____

Applicant Comments Regarding Support Needs:

Please briefly describe the reason(s) for your application. In which areas are you looking for support (e.g., housing/household care, finances, daily activities, education, employment, relationships, social activities, other)?



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CLIENT CONSENT TO COLLECT, USE & RELEASE PERSONAL HEALTH INFORMATION

Having reviewed Reconnect's privacy statement below, I authorize Reconnect to collect information from:

Name: _____

Address: _____

For the purpose of: _____

I hereby freely give my authorization for collecting and using information for services as described above. I understand that my authorization to collect and use information ends when I am no longer a client of Reconnect. I understand that I can withdraw my consent at any time by giving Reconnect notice.

Client Name: _____
print name of client

Date of Birth: _____
date of birth of client (dd/mm/yyyy)

Subst. Decision Maker: _____
(if applicable) print name and specify relationship to client

Phone Number: _____
phone number of substitute decision maker, if applicable, or client

Signature: _____
signature of client or substitute decision maker

Date: _____
date (dd/mm/yyyy)

Having reviewed Reconnect's privacy statement below, I authorize Reconnect to release information to:

Name: _____

Address: _____

For the purpose of: _____

I hereby freely give my authorization for releasing information for services as described above. I understand that my authorization to release information ends when I am no longer a client of Reconnect. I understand that I can withdraw my consent at any time by giving Reconnect notice.

Client Name: _____
print name of client

Date of Birth: _____
date of birth of client (dd/mm/yyyy)

Subst. Decision-maker: _____
(if applicable) print name and specify relationship to client

Phone Number: _____
phone number of substitute decision maker if applicable, or client

Signature: _____
signature of client or substitute decision maker

Date: _____
date (dd/mm/yyyy)

Witness: _____
print name of witness

Date: _____
date (dd/mm/yyyy)

Witness: _____
signature of witness

form 1b revised July 10 2006

Privacy Statement: Reconnect Mental Health Services respects your privacy. Your confidentiality is maintained through our protection of your personal information. Your consent is required for information to be used for your care by Reconnect staff or shared with anyone other than Reconnect staff, except where Ontario's privacy legislation allows. Reconnect staff are available to you to explain our policy with regard to confidentiality. You may have a copy of our privacy policy if you ask.