

Pre-screen Tool for Mental Health and Justice Supportive Housing

Referrers: To ensure all information is provided on the application, please complete the following. Please confirm the applicant has/is:

1. Mental health Diagnosis

- Yes
- No but long-standing issues causing significant disability
- Diagnosis/assessment pending

When/where: _____

- No mental health issues (does not qualify – do not refer)

2. Currently homeless?

Yes:

- Couch surfing with family/friends
- MHJI Short-term crisis bed
- Shelter
- On street
- Pending eviction
- Incarcerated
- Other: _____

No (does not qualify – do not refer)

3. Current involvement with the Criminal Justice System?

Yes

- Charges before the court
- Mental Health Diversion
- On Bail
- On Probation/Parole
- In custody/incarcerated
- NCR/ORB
- Other: _____

No but:

- In the Crisis Prevention Program (Pre-Charge Diversion)
- Was dropped off by police to MHJI Short-term crisis beds

None (does not qualify – do not refer)

4. Charges (past and current) are listed on page 8 of application: Yes No

5. Would this applicant qualify for and be interested in services with Across Boundaries?

(*Across Boundaries* is a leader in providing equitable, inclusive and holistic mental health and addiction services for racialized communities and operates within an anti-racism/anti-oppression framework. For *Across Boundaries*, the term racialized person/group refers to what was previously called "ethnoracial or people of colour".) Yes No

6. Service/Support Providers listed on page 11 of application: Yes No

7. Signed Consent by Referrer and Applicant on page 13: Yes No

Signature of Referrer

Date



Tel: 416-757- MHJI (6454) Fax: 1-866-742-4156

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. The person acting as Referrer must also sign on page 13.

The completed form should be faxed to LOFT at **1-866-742-4156**. You will be contacted within one (1) business day to confirm the receipt of your fax.

Please note that intake procedures differ by agency and various forms of documentation may be required during the intake.

Note: Specific information of the supportive housing options and intake procedures 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 all areas that applicant is interested in)

North York

- East - West of Victoria Park Ave, East Yonge St, South of Steeles Ave, North of Eglinton Ave
- West - West of Yonge St, East of Humber River, South of Steeles Ave, North of Eglinton Ave

Scarborough – East of Victoria Park Ave, South of Steeles Ave, West of Port Union Rd

Downtown

- East – East of the DVP, South of Eglinton Ave, West of Victoria Park Ave
- Central – East of Humber River, South of Eglinton Ave, West of the DVP

Etobicoke – West of Humber River, South of Steeles Ave

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.

June 30, 2011 Edition

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	

June 30, 2011 Edition

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

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
<input type="checkbox"/> No Source of Income	
<input type="checkbox"/> Social Assistance (Ontario Works)	
<input type="checkbox"/> Disability Assistance	
<input type="checkbox"/> Ontario Disability Supp. Prog. (ODSP)	
<input type="checkbox"/> Canadian Pension Plan (CPP)	
<input type="checkbox"/> Employment	
<input type="checkbox"/> Employment Insurance (EI)	
<input type="checkbox"/> Family	
<input type="checkbox"/> 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 11 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.: _____