

Access 1 Common Application Form

WELCOME!

Access 1 is a partnership between several individual support service providers in North York and Scarborough. In order to apply for case management and/or assertive community treatment team (ACTT) services with the organizations listed on this form, **you need to live in North York or Scarborough.**

You may choose either to be considered for the first appropriate organization that can serve you or choose a specific organization with whom you would like to work. Please note that choosing the latter option *may* increase your wait-time for service. Access 1 will contact you when they receive your application to determine your eligibility for the service you are applying for. If you are eligible, you will be placed on a waitlist until services can be offered to you.

Individual Support Services include **mental health case management** and **assertive community treatment team** services. **Crisis management support** is also available to people on the waitlist for individual support services. Listed below are brief descriptions of each of these services:

- **Intensive Case Management** - People with serious mental illness are provided one-on-one case management support to live in the community and be linked to appropriate services by their Case Manager
- **Assertive Community Treatment Teams (ACTT)** - Multi-disciplinary teams provide treatment, rehabilitation and support to people with severe mental illness in their recovery. Specific eligibility criteria apply for this service. **ACTT providers require the following information to be included in this application:**
 - Specific diagnosis
 - History of hospitalizations – supporting hospital records are recommended
 - The referral source needs to provide a detailed explanation in the “**Reason for Referral**” section regarding why the applicant needs ACTT services specifically
- **Crisis Management Support** - Crisis support and goal-oriented planning services for people living with mental illness. This service may be offered on a short-term basis to individuals waiting for case management and ACTT services.

You **may** be eligible to apply for the above services if you are:

- 16 years of age or older
- Have mental health problems that are seriously affecting your life
- Live in North York or Scarborough

Please answer as many questions as you can. Please **PRINT** all answers in ink. Should you have any questions or require assistance with filling in this form, please call Access 1 and a staff person will be happy to help you.

Please read the Declaration and Consent section on page 8 and sign the application form. **The confidentiality of the information you provide will be respected in adherence with the Personal Health Information Privacy Act (PHIPA).**

Mail or fax the completed application form to the address and fax number below. You may also apply on-line at www.access1.ca.

**Applications may be mailed to: Access 1
132 Rainside Road, Unit 2,
Toronto, Ontario M3A 1A3**

Toll-Free #: 1-888-640-1934

Fax: 416-499-9716

PART I

Date of Application: _____

Programs Offered and Boundaries:

Please check off the box for the agency/ies whose services you wish to apply for. Or for case management services, check the first box below if you are interested in being served by the first appropriate organization that can serve you (which may reduce your overall wait-time for service).

*** Some of the agencies listed here provide services to other areas in the City of Toronto. However, this form can be used to only apply to their services in North York or Scarborough.**

First Available Organization:

Case Management

Specific Agencies and Programs

Across Boundaries (people from ethno-racial communities): City Wide *

Case Management (City Wide) Case Management – Transitional Age Youth (North York)

Bayview Community Services (professional referrals only): Eglinton Ave. – Steeles Ave. & Bathurst St. – Kennedy Ave.

Case Management

CMHA (Toronto East): Scarborough

Case Management East (including Rehabilitation Action Program) ACTT * **Specific criteria apply**

CMHA (Toronto West) *

Case Management (West): Steeles Ave.– Lake Ontario & Yonge St. – Highway 427

ACTT (West): Steeles Ave. – Eglinton Ave. & Allan Rd. – Humber River * **Specific criteria apply**

COTA Health: City Wide *

Case Management (North York) Case Management (Scarborough) Hostel Outreach Program (City Wide)

Community Resource Connections of Toronto (CRCT): Downtown, Scarborough and North York *

Case Management (individual – Scarborough and North York as well as Central/Downtown)

Case Management (Family) Case Management (Tamil and Somali)

Case Management (Early Intervention)

Griffin Centre & Community Support Network: City of Toronto *

Interim Case Management (Dual Diagnosis)

North York General Hospital: Victoria Park Ave. – Dufferin St.& Highway 7– Old Southern North York Boundary

ACTT * **Specific criteria apply**

Saint Elizabeth Health Care: Former cities of North York & Etobicoke*

Crisis Management Support

Scarborough Hospital: Victoria Park Ave.– Port Union Rd & Kingston Rd. – Steeles Ave.

Intensive Case Management:

ACTT * **Specific criteria apply**

Sunnybrook Hospital: Sheppard Ave. – St. Clair Ave.& Bathurst St.– Don Valley Parkway *

ACTT (SunPACT) * **Specific criteria apply**

Toronto North Support Services: Eglinton Ave. – Steeles Ave. & Victoria Park Ave. – Humber River

Case management (Community Support Program) Case management (Mental Health Street Outreach)

Case management (Passages French language program)

Where does the applicant live?

North York

Scarborough

PART II

A/ HOW CAN WE CONTACT YOU?

Applicant:

First Name: _____ Last Name: _____

Street Address: _____

Apt. No.: _____ Entry code: _____ Telephone No.: _____ Extension: _____

City: _____ Province: _____ Postal code: _____

Former municipality: North York Scarborough Other 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 No.: _____ 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)*

Referrer's name: _____ Agency: _____

Title: _____

Telephone #: _____ Fax #: _____

Street Address: _____ Apt./Suite No.: _____

City: _____ Province: _____ Postal code: _____

Relationship to Applicant: _____

Do you intend to remain involved with the applicant if he/she secures case management services? Yes No

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

C/ INFORMATION TO HELP US DIRECT YOUR APPLICATION

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

Gender: Male Female Transgender Transsexual Other

Do you have an Ontario Health Card: Yes No Don't know

Do you speak English: Yes No Some

What is your first language(s): English French Other _____

What is your preferred language: English French Other _____

Some individual support service organizations offer a range of supports and services to people from specific ethnoracial communities who are experiencing mental illness. If these services are of interest to you, please check the community/communities that applies to you in order to match you with the most appropriate service. Please note that this question is optional.

- | | | | |
|--------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Aboriginal | <input type="checkbox"/> Caribbean | <input type="checkbox"/> African continent | <input type="checkbox"/> South East Asian |
| <input type="checkbox"/> South Asian | <input type="checkbox"/> West Asian | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Latin American |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Chinese | <input type="checkbox"/> Pacific Islanders |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Unknown | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Other _____ | | | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Spouse/partner & others |
| <input type="checkbox"/> Parents | <input type="checkbox"/> Relatives | <input type="checkbox"/> Non-Relatives |
| <input type="checkbox"/> 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?

- | | |
|--|---|
| <input type="checkbox"/> Approved Homes & Homes for Special Care | <input type="checkbox"/> Private House/Apt.- Client Owned /Market |
| <input type="checkbox"/> Correctional/Probational Facility | <input type="checkbox"/> Rent |
| <input type="checkbox"/> Domicillary Hospital | <input type="checkbox"/> Private House/Apt.- Other/Subsidized |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Retirement Home/Senior's Residence |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Rooming/Boarding House |
| <input type="checkbox"/> Other Specialty Hospital | <input type="checkbox"/> Supportive Housing – Congregate Living |
| <input type="checkbox"/> No fixed address | <input type="checkbox"/> Supportive Housing – Assisted Living
(RTF 24 hr Home and Group Homes) |
| <input type="checkbox"/> Hostel/Shelter | <input type="checkbox"/> Private Non-Profit Housing |
| <input type="checkbox"/> Long-Term Care Facility/Nursing Home | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Municipal Non-Profit Housing | |

What is your primary source of income?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> ODSP | <input type="checkbox"/> Social Assistance (e.g., Ontario Works) |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Employment Insurance |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Disability Assistance |
| <input type="checkbox"/> Family | <input type="checkbox"/> No Source of Income |
| <input type="checkbox"/> Other _____ | |

What is your current employment status?

- | | | |
|--|--|--|
| <input type="checkbox"/> Independent/Competitive | <input type="checkbox"/> Assisted/Supportive | <input type="checkbox"/> Alternative Business |
| <input type="checkbox"/> Sheltered Workshop | <input type="checkbox"/> Non-paid Work Experience | <input type="checkbox"/> No Employment – Other Activity |
| <input type="checkbox"/> Casual/Sporadic | <input type="checkbox"/> No Employment of Any Kind | <input type="checkbox"/> Unknown or Service Recipient Declined |

What is your current education status?

- | | | |
|--|--|--|
| <input type="checkbox"/> Not in School | <input type="checkbox"/> Elementary/Junior High School | <input type="checkbox"/> Secondary/High School |
| <input type="checkbox"/> Trade School | <input type="checkbox"/> Vocational Training Centre | <input type="checkbox"/> Adult Education |
| <input type="checkbox"/> Community College | <input type="checkbox"/> University | <input type="checkbox"/> Other |
| <input type="checkbox"/> Unknown or Service Recipient Declined | | |

Are you currently or in the past been 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 Don't know

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

D/ HEALTH INFORMATION

Is this your first experience with mental illness? Yes No Unknown

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

Have you been diagnosed with a mental illness? Yes No Unknown

If yes, what was the diagnosis(es)? Please be as specific and detailed as possible.

Have you been to hospital (Emergency Room visits and/or in-patient stays) due to mental health challenges in the last three years?

Yes No Unknown

Please provide an estimate of the total number of days that you have spent in Hospital In-Patient Units, due to mental health difficulties, within the past three years:

Estimated number of days: _____

Please list the hospitals you have been in and the dates of your visit:

<u>Hospital</u>	<u>Day/Month/Year To Day/Month/Year</u>
_____	_____
_____	_____
_____	_____

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

Have you ever had an episode of psychosis? Yes No Unknown

Are you currently on a Community Treatment order (CTO) order? 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:

Please list all current medications being used:

E/ APPLICANT'S SUPPORT NEEDS

Applicant is requesting support with:

- | | |
|--|---|
| <input type="checkbox"/> Managing specific symptoms of serious mental health illness | <input type="checkbox"/> Developing daily living skills |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Legal issues |
| <input type="checkbox"/> Housing needs | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Educational opportunities | <input type="checkbox"/> Occupational/Employment/Vocational |
| <input type="checkbox"/> Substance abuse/addictions issues | <input type="checkbox"/> Social supports |
| <input type="checkbox"/> Other: _____ | |
| _____ | |

Referral source comments regarding the applicant's support needs:

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support? **If this is an ACTT referral, please specify why the applicant requires an ACT Team.**

We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of the questions below will not exclude you from service. We know these are sensitive questions and we appreciate you answering them. If you have any recent (i.e., past three years) history of the following, please comment (e.g., when, how many incidents, how severe, outcome):

History of self-harm or suicide threats or attempts: _____

History of substance use or treatment: _____

History of aggressive behavior or violence (verbal, physical, sexual): _____

History of destruction of property (including fire-setting): _____

History of risk of homelessness or currently homeless: _____

F/ EXISTING SUPPORTS

Are you currently working with any other service providers? Yes No Don't know

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

Agency	Name/Contact Person	Service(s) Received	Telephone Number

Please describe the informal supports (e.g., family, friends, faith community, cultural groups/community, other community supports) in your life and how satisfied you are with each of these supports.

G/ PAST SUPPORTS

Have you worked with any other service providers in the past? Yes No Don't know

If yes, please provide the following information on each service provider with whom you worked:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

YOUR DECLARATION AND CONSENT

This section outlines your agreement with the organizations you requested on page 1. We **promise that the confidentiality of the information you have provided will be respected in accordance with all applicable legislation.** By checking the boxes below and signing this application form, you agree to what is set out in the following statements. Please read it carefully before signing.

APPLICANT'S DECLARATION & CONSENT

- I have done my best to ensure that the information provided in this application is correct. Yes No
- I would prefer both my referrer and myself to be contacted for the initial assessment. Yes No
- I understand that in order to determine my eligibility for individual support services and to identify programs that could best meet my needs, the intake staff:
- * Will contact me for further information and to discuss and update me regarding my application. Yes No
I give my permission for this.
 - * May contact and share information with the Referrer (if any) who signs the Referrer's Statement below. Yes No
I give my permission for this.
 - * Contact and share information with the service providers listed on pages 1 and 4 of this application form Yes No
(e.g., psychiatrist, physician, other service providers), except for _____ (if any).
I give my permission for this.
- I understand that this application will be processed by the Access 1 office. I give my permission for this. Yes No
- I understand that if I am eligible for individual support services, this application will be sent to those who are providing the service. I give my permission for this. Yes No
- I understand that once I start receiving service from one organization, the other organizations chosen by me will be informed of this. I give my permission for this. Yes No

Applicant's signature: _____ **Date:** _____

If you have chosen not to consent to any of the above statements, please explain:

REFERRER'S STATEMENT

If another person is referring the applicant, that person (the referrer) must complete this section of the application. By signing this application form, the referrer agrees to what is set out in the statement below. Please read it carefully before signing.

Referrer's statement

To the best of my knowledge, the information contained in this application is correct.

I have discussed this application with the applicant, explained the role of Access 1 and application process, and whenever possible, have completed this application together with the applicant.

I understand that Access 1 will send this application with identifying information only to those agencies to which the applicant has agreed.

Referrer's signature: _____ **Date:** _____