The Access Point

The Toronto Mental Health and Addictions Access Point

# Coordinated Access Referral Form

## A About this form

- With this form, you can apply for individual support services (like Intensive Case Management or Assertive Community Treatment), Supportive Housing, or both.
- This form is designed to assist **The Access Point** in finding housing and/or support services that closely matches the information you provide and the more accurately you fill out this form, the better this match will be. Missing or inaccurate information may slow the assessment process.
- Applicants applying for supportive housing must be willing to accept some level of support from a housing provider. Please read the Declaration and Consent section of the application form and note that consent must be provided in order to process an application.
- The confidentiality of the information you provide will be respected in adherence with the Personal Health Information Protection Act (PHIPA).
- Services provided by **The Access Point** partners is voluntary.

## B Individual Support Services (Check all programs to which you wish to apply)

| | |
|---|---|
| × | **INTENSIVE CASE MANAGEMENT** |

| **Description** | **Eligibility Criteria** |
|---|---|
| One-on-one support to live in the community and be linked to appropriate services by their Case Manager | • Mental health concerns that are seriously affecting your life<br>• 16 years of age or older<br>• Live within the City of Toronto when service is received |

| | |
|---|---|
| × | **ASSERTIVE COMMUNITY TREATMENT TEAMS (ACTT)** |

| **Description** | **Eligibility Criteria** |
|---|---|
| Multi-disciplinary teams provide treatment, rehabilitation and support to people with severe mental illness in their recovery | • Specific Diagnosis with a priority for those experiencing psychosis<br>• History of hospitalizations - supporting hospital records are recommended<br>• The referral source needs to provide a detailed explaination in the “Reason for Referral” section regarding why the applicant needs ACTT services specifically<br>• 16 years of age or older<br>• Live within the City of Toronto when service is received |

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| C | Supportive Housing (Check all programs to which you wish to apply) |
|---|---|

| × | MENTAL HEALTH SUPPORTIVE HOUSING PROGRAM | |
|---|---|---|
| | **Description**<br>Supportive housing for persons with mental health concerns including addictions. The Access Point facilitates linkages to supportive housing programs with various levels of support and includes shared housing such as group homes, boarding homes and rooming houses, as well as independent housing. | **Eligibility Criteria**<br>• 16 years of age or older<br>• Have mental health or mental health and addictions issues<br>• Qualify for a housing subsidy under the criteria set by the Ministry of Health<br>• Must be willing to accept some level of support from housing provider |

| × | PROBLEMATIC SUBSTANCE USE PROGRAM | |
|---|---|---|
| | **Description**<br>Supportive housing for persons with problematic substance use. The Access Point facilitates linkages to low support independent housing. | **Eligibility Criteria**<br>• 16 years of age or older<br>• Have a severe and active substance use challenge<br>• Be homeless or marginally housed<br>• Be a high intensity service user of ER Departments, hospitals, and/or the justice system<br>• Qualify for housing subsidy under the criteria set by the Ministry of Health<br>• Must be willing to accept some level of support from housing provider |

| × | MENTAL HEALTH AND JUSTICE PROGRAM | |
|---|---|---|
| | **Description**<br>Mental Health and Justice Supportive Housing Program. The Access Point facilitates linkages to low support independent housing. | **Eligibility Criteria**<br>• 16 years of age or older<br>• Have mental health challenges that are seriously affecting your life<br>• Be homeless or at immediate risk of homelessness<br>• Have current involvement with the Criminal Justice system at time of housing intake<br>• Be referred by a priority referral source such as various professionals working in the justice system<br>• Qualify for housing subsidy under the criteria set by the Ministry of Health<br>• Must be willing to accept some level of support from housing provider |

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## D Individual Support Services Agency Preferences

- Leave this section blank if you wish to be connected with the first available agency
- If you would prefer NOT to be connected to an agency enter an 'x' beside its name
- Indicate your first choice of agency by entering a '1' beside its name; Indicate your second choice of agency by entering a '2' beside its name; Indicate your third choice of agency by entering a '3' beside its name

| Is this a team to team transfer? | YES | NO |
|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | 416 Community Support for Women | | CTYS - Central Toronto Youth Services | | Sound Times |
| | Across Boundaries | | Hong Fook Mental Health Association | | St. Joseph's Health Centre |
| | Across Boundaries (Youth) | | LOFT Community Services | | St. Michael's Hospital |
| | Alternatives | | Madison Community Services | | Sunnybrook Hospital |
| | Bayview Community Services Inc. | | Margaret's Housing & Community Support Services | | The Scarborough Hospital |
| | CMHA (Toronto East) | | Mount Sinai Hospital - ACTT | | Toronto East General Hospital |
| | CMHA (Toronto West) | | North York General Hospital - ACTT | | Toronto North Support Services |
| | Cota | | Reconnect Mental Health Services | | University Health Network |
| | CRCT | | Regeneration Community Services | | |

## E Supportive Housing Agency Preferences

- Leave this section blank if you wish to be connected with the first available agency
- If you would prefer NOT to be connected to an agency enter an 'x' beside its name
- Indicate your first choice of agency by entering a '1' beside its name; Indicate your second choice of agency by entering a '2' beside its name; Indicate your third choice of agency by entering a '3' beside its name
- All Housing programs require applicants to be willing to receive support services offered by the housing providers.

| | | | | | |
|---|---|---|---|---|---|
| | Accommodation Information & Support | | Good Shepherd Non-Profit Homes | | Parkdale Activity-Recreation Centre |
| | Bayview Community Services Inc. | | Habitat Services | | Pilot Place Society |
| | Centre for Addiction and Mental Health | | Hong Fook Mental Health Association | | Progress Place |
| | Chai Tikvah Foundation | | House of Compassion | | Regeneration Community Services |
| | CMHA Toronto | | Houselink Community Homes | | Rouge Valley Health System |
| | COPA | | Jean Tweed Centre | | St Stephens Community House |
| | Community Outreach Services | | John Howard Society | | St. Jude Community Homes |
| | Cota | | LOFT Community Services | | Street Haven at the Crossroads |
| | Eden Community Homes | | Madison Community Services | | Toronto Community Addictions Team - TCAT |
| | Fred Victor Centre | | Mainstay Housing | | WoodGreen Community Services |
| | George Herman House | | Margaret's Housing & Community Support Services | | YWCA Toronto |

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## F Contact Information

| | |
|---|---|
| First Name: | Last Name: |
| Aliases (AKA): | |
| Street Address: | |
| Nearest Intersection: | |
| Apt #: | Entry Code: |
| City: | Province: |
| Postal Code: | |
| Telephone #: | Extension: |
| Alternate Phone: | |
| Email: | |

| | | | |
|---|---|---|---|
| Are you currently homeless? | YES NO | Are you currently at risk of becoming homeless or marginally housed? | YES NO |

If no fixed address please provide possible locations where person might be found:

## G Alternate Contact Information

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

| | |
|---|---|
| First Name: | Last Name: |
| Phone: | Extension: |
| Relationship: | Organization: |

| | |
|---|---|
| Can a message be left at the number provided? | YES NO |

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| H | General Information |
|---|---|

| | | |
|---|---|---|
| Have you completed an Ontario Common Assessment of Need (OCAN) in the past 6 months? | | YES NO UNSURE |
| Date of Birth (YYYY/MM/DD): | | |
| Gender Identity: | | |
| Do you have an Ontario Health Card? | | YES NO UNSURE |
| Ontario Health Card Number: | | |
| Do you speak English? | | YES NO UNSURE |
| First Language | Preferred Language | |
| Do you need an interpreter? | | YES NO |
| What is your ethnicity and/or culture?<br>i.e. what culture or ethnicity do you identify with | | |
| Are you of Aboriginal descent? | | YES NO UNSURE |
| Immigration Status: | Year of arrival in Canada: | |
| Permanent Resident Card Number: | | |
| Would you qualify for, and be interested in, services for racialized communities?<br>refers to people/groups who were previously called “ethno racial” or “people of colour” | | YES NO UNSURE |

| I | Financial Information |
|---|---|

| | |
|---|---|
| What is your primary source of income? | Secondary Source of Income? |
| Total Monthly Income: | Value of Assets (e.g. RRSPs): |
| If you have applied for supplemental income sources (e.g. CPP, EI, etc) but are not yet receiving it, please provide the details: | |

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| I | Financial Information (Continued) | | |
|---|---|---|---|
| Do you have a trustee or Power of Attorney for finances? | | YES NO UNSURE | |
| Name: | Phone: | | |
| Email: | | | |
| What is your current employment status? | | | |
| What is your highest level of education? | | | |
| Are you currently in school/training now? | | YES NO UNSURE | |
| Who do you presently live with? | | | |
| What type of housing do you presently live in? | | | |

| J | Health Information | |
|---|---|---|
| Is this your first experience with mental illness? | | YES NO UNSURE |
| How long have you been experiencing mental health difficulties (in years)? | | |
| Have you been formally diagnosed with a mental illness? | | YES NO UNSURE |
| If yes, what is/was the primary diagnosis? | | |
| Have you ever experienced psychosis? | | YES NO UNSURE |
| If you are struggling with any other mental health issue, please explain/state: | | |
| Have you been to hospital (Emergency Room visits and/or in-patient stays) due to mental health issues in the last two years? | | YES NO UNSURE |

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| J | Health Information (Continued) |
|---|---|

Please provide an estimate of the total number of days that you have spent in hospital in-patient units, due to mental health issues, within the past two years (estimate in days):

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

| | | | |
|---|---|---|---|
| Are you currently in the hospital due to mental health issues? | YES | NO | |
| If yes, are you currently designated ALC (alternative level of care)? | YES | NO | |
| Are you currently on a Community Treatment Order (CTO)? | YES | NO | |
| **Do you have any other illnesses/disability?** | | | |
| Concurrent Disorders (substance use and mental illness)? | YES | NO | UNSURE |
| Dual Diagnosis (developmental disability and mental illness)? | YES | NO | UNSURE |
| Neurological (head/brain Injury, epilepsy, Parkinson's, cognitive disorders etc.) | YES | NO | UNSURE |
| Other chronic illness and/or physical disabilities (e.g. hypertension, diabetes, allergies) | YES | NO | UNSURE |
| One of our providers specializes in supporting persons living with HIV/AIDS. Would this apply to you? | YES | NO | |

If YES to any of the above, please describe:

If you are struggling with any intellectual disability, please explain/state:

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| J | Health Information (Continued) |
|---|---|

| Substance Use Concerns | | |
|---|---|---|
| Do you have an active and severe substance use concern? | YES NO UNSURE | |
| If yes, what is your substance of choice? | | |
| How long have you been concerned with substance use issues (in years)? | | |
| Have you visited a Hospital Emergency Department (ER), due to your substance use concerns in the previous year? | YES NO | |
| If yes, number of ER visits in the previous year: | Number of ER visits in the previous 2 months: | |
| Have you been hospitalized for substance use (including acute, rehabilitation and complex continuing care) in the previous year? | YES NO | |
| If yes, please state the number of hospital in-patient days for substance use in the previous year: | | |
| Have you been admitted to a Withdrawal Management System (WMS) (i.e. residential WMS, Community WMS, or day WMS), due to your substance use concerns in the previous year? | YES NO | |
| If yes, please state the number of admissions to WMS in the previous year: | | |
| Have you had any involvement with the Criminal Justice System within the past year? | YES NO | |
| If yes, how many separate and unrelated contacts have you had? | | |

| Medical Contacts and Medications | |
|---|---|
| Do you have a psychiatrist? | YES NO |
| Psychiatrist's name: | |
| Address: | |
| Telephone #: | Fax #: |
| Email: | |

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## J Health Information (Continued)

### Medical Contacts and Medications (Continued)

| | |
|---|---|
| Do you have a physician (e.g., GP, family doctor, walk-in clinic doctor)? | YES NO |
| Physician name: | |
| Address: | |
| Telephone #: | Fax #: |
| Email: | |
| Please list all current medications being used: | |

## K Support Needs

Applicant's comments regarding support needs:

Please briefly describe the reason(s) for the referral. What is the present difficulty and in which area would the applicant benefit from support?
If this is an ACTT referral, please specify why the applicant requires the level of intensity of service provided by an ACT team.

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| K | Support Needs (Continued) | |
|---|---|---|
| **Existing Support** | | |
| Are you currently working with any other service providers? | | YES NO |
| If yes, please provide the following information on each service provider with whom you are currently working: | | |
| **1** | Agency Name: | Program Name: |
| Contact Name: | | |
| Services Received: | | |
| Phone: | | Email: |
| **2** | Agency Name: | Program Name: |
| Contact Name: | | |
| Services Received: | | |
| Phone: | | Email: |
| **3** | Agency Name: | Program Name: |
| Contact Name: | | |
| Services Received: | | |
| Phone: | | Email: |
| 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: | | |

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| K | Support Needs (Continued) | | |
|---|---|---|---|
| **Past Support** | | | |
| Have you worked with any other service providers in the past? | | | YES NO |
| If yes, please provide the following information on each service provider with whom you have worked in the past: | | | |
| **1** | Agency Name: | Program Name: | |
| Contact Name: | | | |
| Services Received: | | | |
| Phone: | | Email: | |
| **2** | Agency Name: | Program Name: | |
| Contact Name: | | | |
| Services Received: | | | |
| Phone: | | Email: | |
| **3** | Agency Name: | Program Name: | |
| Contact Name: | | | |
| Services Received: | | | |
| Phone: | | Email: | |
| **Additional Support Needs** | | | |
| In order to match your needs to an appropriate housing vacancy, please indicate what level of support you would need from the Supportive Housing Provider in the following areas:<br>Please note: your selections in this chart will inform The Access Point as to which housing options would be appropriate for you and will affect which vacancies you are contacted for. If you need assistance or further information, please contact **The Access Point** at (416) 640-1934. | | | |
| Would you like support with the following? | | | |
| **Housing** | Housing needs | | YES NO |
| | Looking after your home | | YES NO |

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| K | Support Needs (Continued) | |
|---|---|---|
| **Additional Support Needs (Continued)** | | |
| **Social Support** | Developing positive relationships | YES NO |
| | Meeting new people / Social and peer support | YES NO |
| **Health & Wellness** | Managing specific symptoms | YES NO |
| | Diabetes education | YES NO |
| | Self-managing medication | NONE SOME A LOT |
| | Dealing with drug and alcohol use | YES NO |
| | Wellness recovery action planning | YES NO |
| | Physical health and education | YES NO |
| | Getting to appointments | YES NO |
| | Self-Care | NONE SOME A LOT |
| **Food and Nutrition** | Nutrition and diet information | YES NO |
| | Shopping | YES NO |
| | Assistance with meal preparation | NONE SOME A LOT |
| | Do you need meals provided? | YES NO |
| **Finances** | Financial responsibilities | YES NO |
| **Legal** | Legal issues | YES NO |
| | Self-advocacy - knowing your rights | YES NO |
| **Maintaining Safety** | Avoiding unsafe situations | YES NO |
| | Avoiding crisis and dealing with anger | YES NO |

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## K Support Needs (Continued)

### Additional Support Needs (Continued)

| | | |
|---|---|---|
| **Employment and Education** | Understanding English, reading, writing, literacy skills | YES NO |
| | Improving employability and career possibilities | YES NO |
| | Education / training | YES NO |
| **Daily Activities** | Using transportation / TTC | YES NO |
| | Adding structure to your day | YES NO |
| | Developing daily living skills | YES NO |
| **Other Areas** | Please Describe: | |

### Safety Risks

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)

If you struggle with any of the items listed, please circle how long it has been since the last incident:

| | | | | |
|---|---|---|---|---|
| Alcohol use that causes you harm | N/A | 6 months | 6 months -1 year | 1 - 5 years |
| Thoughts of suicide | N/A | 6 months | 6 months -1 year | 1 - 5 years |
| Suicide attempts | N/A | 6 months | 6 months -1 year | 1 - 5 years |
| Self harm | N/A | 6 months | 6 months -1 year | 1 - 5 years |

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| K | Support Needs (Continued) | | | | |
|---|---|---|---|---|---|
| **Safety Risks (Continued)** | | | | | |
| Drug use that caused harm to you | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Lack of attention while smoking | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Mishandling fire / Fire setting | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Assault by you - physical | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Assault by you - sexual | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Assault by you - verbal | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Problems with anger management | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Inappropriate sexual behaviour | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Destroying/abuse of property | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Gambling | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Issues with collecting things | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Problems with violence | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| History of homelessness / Risk of homelessness | N/A | 6 months | 6 months - 1 year | 1 - 5 years |
| Comments or other challenges: | | | | |

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| L | Legal Involvement | | |
|---|---|---|---|
| Are you currently or in the past been involved with the criminal justice system? | | | YES NO |
| If yes, please state the number of contacts with the justice system in the previous year: | | | |
| **Please complete the following if you have current legal involvement (check all that apply)** | | | |
| **Pre-Charge** | | **Outcomes** | |
| | Pre-Charge Diversion | | Charges withdrawn |
| | Court Diversion Program | | Conditional sentence |
| **Pre-Trial** | | | Stay of proceedings |
| | Awaiting fitness assessment | | Restraining order |
| | In community on own recognizance | | Awaiting sentence |
| | Awaiting trial (with or without bail) | | Peace bond |
| | Unfit to stand trial | | NCR |
| | Awaiting criminal responsibility assessment (NCR) | | Suspended sentence |
| **Custody Status** | | | Conditional discharge |
| | ORB detained - community access | **Other** | |
| | On probation | | No legal problem |
| | ORB conditional discharge | | Other criminal/legal problems |
| | Incarcerated | | Unknown |
| | On parole | | |

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| L | Legal Involvement (Continued) |
|---|---|

**Please list all current and previous charges (including counts, the charge, and the date).**

| Counts | Charges | Date (Indicate if ongoing) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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| M | Housing Preferences (please fill out this section if you are applying for supportive housing) |
|---|---|

| | |
|---|---|
| Are you prepared to live anywhere in the City of Toronto? | YES NO |

**If not, please indicate your location preference (check as many as you like)**
Please note: The Access Point will only contact you for vacancies in the areas you indicate below.

| | | | |
|---|---|---|---|
| | West End of Toronto<br>Bathurst to Islington, Lawrence to Lakeshore | | North York West<br>North of Lawrence, West of Yonge to Islington |
| | East End of Toronto<br>Don Valley to Victoria Park, Lawrence to Lakeshore | | Etobicoke<br>West of Islington |
| | Downtown Core of Toronto<br>Bathurst to Don Valley, Lawrence to Lakeshore | | Scarborough<br>East of Victoria Park |
| | North York East<br>North of Lawrence, East of Yonge to Victoria Park | | |

| | |
|---|---|
| Do you require housing for a family?<br>Note: there is a limited amount of housing available for families | YES NO |

**If yes, please provide the following information about your family**

| Name | Relationship | Date of Birth | Gender | Monthly Income |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| Do you want to live in housing for: | MEN & WOMEN MEN ONLY WOMEN ONLY |
| Do you require a wheelchair accessible unit? | YES NO |

Some of the Network agencies have contracts with owners of boarding homes to provide accommodation and meals for tenants. It is often possible to match an applicant to a boarding home more quickly than other housing.

| | |
|---|---|
| Would you like to be referred to a boarding home? | YES NO |
| Would you share a room with someone you don't know? | YES NO |

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| M | Housing Preferences |
|---|---|

**What other types of supportive housing will you accept (check all that apply)?**

| | | | |
|---|---|---|---|
| | Rooming House / Shared living (House or Apartment) | | My Own Apartment - Dedicated Building<br>All tenants are people living with mental health challenges |
| | My Own Apartment - Scattered Unit<br>Some tenants are people living with mental health challenges | | |

| | |
|---|---|
| How often would you like staff onsite/visiting your unit?<br>If applicable | 24 HOURS DAILY OCCASSIONALLY |

**Medical Supports within Housing**

| | |
|---|---|
| Do you require housing/support services suitable for a person with physical ability issues? | YES NO |
| If yes, please explain: | |
| Are you living with diabetes or a pre-diabetic condition? | YES NO |

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| M | Housing Preferences (Continued) |
|---|---|

**Applicants Previous Housing References and History**

Under the Residential Tenancies Act, in selecting prospective tenants, landlords may use income information, credit cards, credit references, rental history, guarantees or other similar business practices permitted under the Human Rights Code regulations.

Please list your housing history for the past three years:

| | | |
|---|---|---|
| 1 | Address: | |
| Type of Housing: | | Landloard/Agency: |
| Telephone #: | | |
| Date Moved In (YYYY/MM/DD): | | Date Moved Out (YYYY/MM/DD): |
| Reason for Leaving: | | |
| 2 | Address: | |
| Type of Housing: | | Landloard/Agency: |
| Telephone #: | | |
| Date Moved In (YYYY/MM/DD): | | Date Moved Out (YYYY/MM/DD): |
| Reason for Leaving: | | |
| 3 | Address: | |
| Type of Housing: | | Landloard/Agency: |
| Telephone #: | | |
| Date Moved In (YYYY/MM/DD): | | Date Moved Out (YYYY/MM/DD): |
| Reason for Leaving: | | |

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## N Privacy Policy

### Commitment to Privacy

At **The Access Point** we take your privacy seriously. Our goal is to ensure that all personal health information (PHI) is properly collected and protected. We store your PHI in a responsible way and dispose of it in a safe and timely manner when it is no longer required. We take responsible steps as required by privacy legislation to maintain the confidentiality and security of the PHI you provide to us.

### Purposes for Collection Use and Disclosure of PHI

We collect, use and disclose your PHI to identify your needs in order to provide you with housing and/or individual mental health support services, including the following:

- We collect all relevant information contained in the records maintained by the organizations and individuals listed in this application. This may include your psychiatrist, physician, other support agencies, the referrer, and/or the public guardian and trustee/attorney listed on the application.
- We collect, use and disclose your PHI to make referrals for housing and/or mental health support services, obtain payment for such services, and to fulfill other purposes required or permitted by law.
- If you are eligible for housing and/or support services, this application will be sent to agencies that will be providing services to you.
- The Access Point or any of the service providers who receive your PHI may be required by law to disclose it to a person or organization other than those listed herein without your consent in limited circumstance, such as emergencies or child welfare concerns.
- We collect, use and disclose de-identified PHI about our applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting to our funders.

### Privacy Officer

In order to review your PHI or if you have any questions or concerns about your privacy, please contact our Privacy Officer at (416) 640-1934. If you still have concerns, you may contact the Office of the Information and Privacy Commissioner/Ontario at 2 Bloor Street East, Suite 1400, Toronto, Ontario M4W 1A8, (416) 326-3333.

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| O | Applicant's Declaration and Consent |
|---|---|
| By checking the boxes below, you agree to what is set out in the following statements. Please read it carefully. | |
| × | I declare I am the applicant for housing and/or for support services. |
| × | I have done my best to ensure that the information provided in this application is correct. |
| × | **The Access Point** may contact and share information with the Referrer (if any) who completes the Referrer's Statement below. |
| × | I understand that I may withdraw or change this consent at any time by writing **The Access Point** Director (661 Yonge Street, Toronto, ON, M4Y 1Z9), except where information has already been shared. |
| × | I understand that if I do not consent or withdraw my consent, that this may affect my ability to receive services. |
| × | I understand **The Access Point** will be contacting me to verify my consent to the processing of the application. |
| I do not consent to the sharing of information with: | |
| If you have chosen not to consent to any of the above statements, please explain | |
| × | I confirm that I have read and understand this form and consent to the collection, use and disclosure of PHI as described in the form. |

| Substitute Decision Maker (SDM) | |
|---|---|
| If the person filling out this form is a SDM for the applicant, then the questions in this form relate to information about the individual needing support (applicant). If you are the SDM for the applicant, please provide the following information: | |
| Name: | |
| Address: | |
| Telephone #: | Email: |
| Relationship: | Type of SDM: |
| × | The SDM hereby declares that he or she is the person authorized under the Personal Health Information Protection Act, 2004 to consent to the collection, use and disclosure of personal health information about the applicant and consents on behalf of the applicant. |

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# Coordinated Access Referral Form

| P | Referral Source/Worker/Agency - for non self-referrals | |
|---|---|---|
| Referrer's Name: | | Referrer's Agency: |
| Title: | | Telephone #: |
| Cell #: | | Fax #: |
| Email: | | |
| Address: | | Apt/Suite: |
| City: | | Province: |
| Postal Code: | | Relationship: |

| | |
|---|---|
| Is the applicant aware of this referral? | YES NO |
| Is this a Health Link client? | YES NO |
| Which Health Link: | |
| Are you a Health Link Priority Referral Source? | YES NO |
| Do you intend to remain involved with the applicant if he/she secures individual support services/ housing services? | YES NO |
| If yes, please describe the level of involvement that you intend to maintain: | |
| If no, please describe reason why: | |

**Referrer's Declaration**

If a person other than the applicant or SDM is completing this application and making the referral, the referrer must complete the declaration below. Please read it carefully. Please note applications will only be accepted with the consent of the applicant or Substitute Decision Maker if there is one.

| | |
|---|---|
| × | 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 **The Access Point** and the application process, and whenever possible, have completed the application together with the applicant. |

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# Coordinated Access Referral Form

| P | Referral Source/Worker/Agency - for non self-referrals (Continued) |
|---|---|
| **Referrer's Declaration (Continued)** | |
| × | I understand that **The Access Point** will send this application with identifying information only to those agencies to which the applicant has agreed. |
| × | I have obtained the applicants knowledge and voluntary consent to make this referral and to the collection, use and disclosure of PHI as set out in this application. |