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 • 16 years of age or older • 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 • History of hospitalizations - supporting hospital records are recommended • The referral source needs to provide a detailed explaination in the “Reason for Referral” section regarding why the applicant needs ACTT services specifically • 16 years of age or older • 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 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** • 16 years of age or older • Have mental health or mental health and addictions issues • Qualify for a housing subsidy under the criteria set by the Ministry of Health • Must be willing to accept some level of support from housing provider

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

×	MENTAL HEALTH AND JUSTICE PROGRAM	
	Description Mental Health and Justice Supportive Housing Program. The Access Point facilitates linkages to low support independent housing.	**Eligibility Criteria** • 16 years of age or older • Have mental health challenges that are seriously affecting your life • Be homeless or at immediate risk of homelessness • Have current involvement with the Criminal Justice system at time of housing intake • Be referred by a priority referral source such as various professionals working in the justice system • Qualify for housing subsidy under the criteria set by the Ministry of Health • 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		West Neighbourhood House (formerly St. Christopher House)

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? 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? 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:
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 Bathurst to Islington, Lawrence to Lakeshore		North York West North of Lawrence, West of Yonge to Islington
	East End of Toronto Don Valley to Victoria Park, Lawrence to Lakeshore		Etobicoke West of Islington
	Downtown Core of Toronto Bathurst to Don Valley, Lawrence to Lakeshore		Scarborough East of Victoria Park
	North York East North of Lawrence, East of Yonge to Victoria Park		

Do you require housing for a family? 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 All tenants are people living with mental health challenges
	My Own Apartment - Scattered Unit Some tenants are people living with mental health challenges		

How often would you like staff onsite/visiting your unit? 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.

Signature:	Date:

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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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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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.
Signature:	Date: