Canadian Mental Health Association
Sault Ste. Marie Branch
Mental health for all

SUPPORTED PERMANENT RESIDENTIAL HOUSING REFERRAL

Today's Date _____

Name (Please Print) _____ LAST _____ FIRST **Gender:** _____

Date of Birth: _____ MM - DD - YYYY **Health Card Number:** _____ _____

Preferred Language: ☐ English ☐ French ☐ Other _____ **Phone:** _____

Referral Source: _____ **Phone:** _____
Please provide details - Staff Name + Agency, Program or Service

Supportive Permanent Residential Care Housing Program

This program provides people with complex and severe mental illness and addictions issues an opportunity to be housed in suitable, accessible, affordable, sustainable, and permanent housing with 24 hour / 7 day / week support.

The program is the result of a collaborative partnership involving the NE LHIN, the mental health and addiction providers from Algoma and the Sault Ste. Marie Social Services Administration Board (SSMSSAB). In particular, the Sault Ste. Marie Housing Corporation will be the landlord and provide the "bricks and mortar" and the Canadian Mental Health Association will deliver a 24 hour / 7 day / week supportive housing model.

Individuals with complex and severe mental illness and addictions issues can be difficult to house due to their lengthy hospitalizations (often resulting in loss of housing), loss of family and community supports, a long history of evictions, inability to be employed, poor impulse control, low medication compliance, poor nutrition, decreased health, and increasing stigmatization and vulnerabilities as they age.

The Supportive Permanent Residential Care Housing Program will operate within a self-care psychosocial and recovery model which features Individual Rehabilitation Plans based on establishing mutually agreed upon goals which are reviewed on a regular basis.

Referrals can be made directly to Canadian Mental Health Association and all referrals will be reviewed by the Joint Agency Review Committee.

Please provide accurate information and complete all sections to ensure that the Selection Committee has the best information available for review.

REQUIRED ELIGIBILITY CHECKLIST

- ☐ 18 years of age and over
- ☐ A diagnosed serious and persistent mental illness with or without an addictions issue and currently stable
- ☐ Under the care of a primary care provider (Dr., NP) **Name:** _____
- ☐ Access to psychiatric care and consultation prior to residency **Name:** _____
- ☐ Approved or able to be approved for 'Rent-Geared-To-Income' housing
- ☐ Willing to abide by the residence requirements and participate in daily programming
- ☐ Willing to complete personal care plan

Those typically not eligible:

> situational life stressors that result in temporary problems in living independently
> people who experience age related cognitive decline (e.g., dementia) are better served by senior services
> people with only addictions issues
> people who pose a significant risk to others or people who are sexual predators

For more information contact Central Access - Monday to Friday 8:30 a.m. - 8:00 p.m. @ 705-759-5989 or
Fax: 705-945-0261 - Email *information@cmhassm.com*

ASSESSMENT OF RISK

☐ Currently identified as 'Alternate Level of Care' How long _____ (Months)
ALC Definition - A patient occupying a bed in a hospital who does not require the intensity of resources/services provided in this care setting (Acute care services)

☐ Currently an inpatient at hospital City _____ How long _____ (Months)

☐ Currently on a 'Community Treatment Order' Expiry Date _____

Number of moves or evictions over past 2 years # _____

Currently facing an eviction order? ☐ Yes ☐ No Date: _____

Current legal issues? ☐ Yes ☐ No Please describe: _____

HOUSING

Please describe your current housing situation (check only one)

☐ No place to stay at all (no fixed address)
☐ Living with aging parents
☐ Private house/apartment
☐ Rooming and/or Boarding house
☐ Hostel and/or emergency shelter
☐ Short term Group Home
☐ Correctional/Probational facility
☐ Other (specify) _____

☐ Substandard apartment
☐ Family Home
☐ Municipal Not-For-Profit (subsidized)
☐ Motel / Hotel
☐ Temporary with friends
☐ Transitional Housing ** (Temporary housing set-up to transition residents into permanent, affordable housing. Usually a room or apartment in a residence with support services. i.e.: Beginnings Transition House; Elgin Place)
☐ Mental Health facility (i.e.: Sault Area Hospital In-Patient Psychiatric Unit; Health Sciences North: North Bay Regional Health Centre)
Location _____

Do you have any special requirements for housing such as:

Accessibility issues ☐ Yes ☐ No

Dependent children living with you ☐ Yes ☐ No

How many times have you moved in the past 12 months? # _____

** Has the persons stay in transitional housing extended beyon the normal limits of the program?

☐ Yes ☐ No If YES - by how many months _____

EMERGENCY SERVICES/HOSPITALIZATION HISTORY

Have you been hospitalized in the past 12 months due to your mental illness? ☐ Yes ☐ No

If YES, number of hospitalization days _____ Number of admissions in past 12 months _____

Reason for admission _____

Have you been to the hospital emergency department in the last 12 months? ☐ Yes ☐ No

If YES, how many times? _____

What issues took you to the hospital emergency department? (please check all that apply)

☐ Breathing problems	☐ Attempted Suicide	☐ Heart problems
☐ Anxiety/panic	☐ Alcohol poisoning	☐ Car accident
☐ Depression	☐ Seizures	☐ Illness (such as flu)
☐ Overdose	☐ Cuts/injuries requiring stitches	

☐ Other (please describe) _____

Have you had contact with Crisis Services in the past 12 months? ☐ Yes ☐ No

If YES, number of times _____

Have you had contact with Police Services in the past 12 months? ☐ Yes ☐ No

If YES, number of times _____

Have you accessed or been admitted to Detox/Withdrawal Management or Police Detox in the past 12 months? ☐ Yes ☐ No If YES, number of times _____

HEALTH AND MENTAL HEALTH

Do you have a diagnosed mental illness? ☐ Yes ☐ No

What is your PRIMARY diagnosis? _____

Axis I: Schizophrenia, Depression, Bipolar Disorders Axis II: Personality disorders, Intellectual Disabilities

Duration ☐ 1 - 4 yrs. ☐ 5 - 9 yrs. ☐ 10 + yrs.

Do you have any undiagnosed MENTAL health concerns? ☐ Yes ☐ No

If YES, please list any concerns: _____

_____

Do you experience any PHYSICAL health concerns? ☐ Yes ☐ No

If YES, please list any current or previous physical health diagnoses/concerns: (e.g.: diabetes; heart; lung, etc.)

_____

_____

SUBSTANCE USE HISTORY

Do you have a substance abuse issue and/or addiction? ☐ Yes ☐ No

Please explain: _____

_____

_____

What drugs (including alcohol) have you used in the last 12 months? _____

_____

How has alcohol/drug use affected your life? _____

_____

How often do you use alcohol? _____

How often do you use other illegal or non-prescribed drugs? _____

Do you smoke cigarettes? ☐ Yes ☐ No How many cigarettes daily? _____

SUPPORT NETWORK

Do you have a network of support people from the following examples? (please check all that apply)

Family Members ☐ Yes ☐ No

How many: ☐ 1 ☐ 2 ☐ 3+

Addiction Counsellor ☐ Yes ☐ No

Name: _____

PACT (Program for Assertive Community Treatment) ☐ Yes ☐ No

Name: _____

Intensive Case Management (Algoma Public Health) ☐ Yes ☐ No

Name: _____

Supportive Peers or Friends ☐ Yes ☐ No

How many: ☐ 1 ☐ 2 ☐ 3+

Sponsor ☐ Yes ☐ No

Self-Help/Support Group ☐ Yes ☐ No

Canadian Mental Health ☐ Yes ☐ No

Name: _____ Program: _____

Substitute Decision Maker ☐ Yes ☐ No

Name: _____

Other (list any other Agency or service involvement)

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

ADDITIONAL SUPPORTS REQUIRED

- ☐ Personal planning and decision-making (Recovery Planning)
- ☐ Accessing Health Treatment Services (e.g., Family Dr., Psychiatric Treatment
- ☐ Financial (e.g., budgeting, application for pension)
- ☐ Friendship and social contacts
- ☐ Household skills training (e.g., cooking, cleaning laundry)
- ☐ Legal supports, Diversion/ Court Support
- ☐ Shopping (e.g., food, clothing)
- ☐ Personal Care (hygiene/grooming)
- ☐ Education
- ☐ Medication management
- ☐ Employment
- ☐ Literacy
- ☐ Volunteer work
- ☐ Recreation/leisure activities
- ☐ Support Groups/self-help
- ☐ Emotional support
- ☐ Accessing Social Services
- ☐ Crisis Intervention planning
- ☐ Risk Concerns - Self
- ☐ Risk Concerns - Others
- ☐ Safety Issues/Vulnerability (specify) _____

_____

- ☐ Other (specify) _____

_____

MARITAL STATUS

☐ Single (never married) ☐ Separated or Divorced ☐ Married/Partner/Common-Law

☐ Widow/Widower Number of Dependents_____ Ages: _____ _____ _____ _____

INCOME

Are your finances handled by the Public Guardian & Trustee (PG&T) ☐ Yes ☐ No

Are you receiving ODSP? ☐ Yes ☐ No for: ☐ Income Support ☐ Employment Support

If YES, workers name: _____ Phone: _____

Are you receiving Ontario Works? ☐ Yes ☐ No

If YES, workers name: _____ Phone: _____

Are you receiving CPP Disability? ☐ Yes ☐ No

What is your monthly income? Source _____ Amount $ _____

Source _____ Amount $ _____

Source _____ Amount $ _____

TOTAL $ _____

EDUCATION

☐ No formal schooling
☐ Some primary school
☐ Completed primary school
☐ Some high school
☐ Completed high school
☐ Some college
☐ Completed college
☐ Some university
☐ Completed university

EMPLOYMENT STATUS

Please check your current status:

☐ Full-Time ☐ Unemployed ☐ Not in labour force ☐ Disabled
☐ Part-Time ☐ Student/Retraining ☐ Retired ☐ Unknown
☐ Volunteering

Previous employers (if applicable):

Employer: _____ Date: _____
Employer: _____ Date: _____
Employer: _____ Date: _____

LEGAL HISTORY

Are you on probation? ☐ Yes ☐ No Are you on parole? ☐ Yes ☐ No

If YES to any of the above, until when? _____

If YES, please list conviction and conditions of probation/parole: _____

Do you have any outstanding charges, bench warrants? ☐ Yes ☐ No

Do you have any outstanding court dates? ☐ Yes ☐ No

Have you had a recent (past 6 months) criminal reference check completed? ☐ Yes ☐ No

If NO, would you be willing to submit to one? ☐ Yes ☐ No

_____ _____
Signature of Applicant *Date*

Assistance with completion of referral provided by:

_____ _____
Name (please print) *Date*