

Central West LHIN Registration Form Mental Health and Addictions Services



Inquiries: 905-795-8742 ext. 223 / intake@shipshey.ca

Website: www.shipshey.ca

Acceptance of registration requires legible answers for all fields on the two pages, including indicating the choice not to answer.

REGISTRANT'S INFORMATION										Health Card #:																								
Last Name:										Gender:																								
First Name:										<input type="checkbox"/> Female					<input type="checkbox"/> Trans																			
Birth Date:										<input type="checkbox"/> Intersex					<input type="checkbox"/> Do not Know																			
Day				Month				Yr				<input type="checkbox"/> Male					<input type="checkbox"/> Prefer not to answer																	
Street Address:										<input type="checkbox"/> Other:																								
City/Town, Prov.:										Postal Code:																								
Email:										Internet access?																								
										<input type="checkbox"/> No					<input type="checkbox"/> Yes																			
Home:										Cell:																								
										<input type="checkbox"/> Yes, you may text																								
What details can be left in a message? <small>(after the second failed attempt to contact you, your alternate contact will be phoned/emailed)</small>										<input type="checkbox"/> Caller's Name					<input type="checkbox"/> Agency Name					<input type="checkbox"/> Phone number														
										<input type="checkbox"/> Reason for call					<input type="checkbox"/> Follow up Required					<input type="checkbox"/> Appointment Info														
Barrier to Communication:										<input type="checkbox"/> Limited/no English					<input type="checkbox"/> Cognitive					<input type="checkbox"/> Hearing					<input type="checkbox"/> Sight					<input type="checkbox"/> Other:				
If not most comfortable speaking in English, is an interpreter needed?										<input type="checkbox"/> No					<input type="checkbox"/> Yes					<input type="checkbox"/> Do not know														
Is this referral from an Emergency Department Visit for Addictions or Mental Health?										<input type="checkbox"/> No					<input type="checkbox"/> Yes, please specify the hospital:																			
Is this referral from a Mental Health Inpatient unit?										<input type="checkbox"/> No					<input type="checkbox"/> Yes, specify hospital:																			
Alternate Contact:										Relationship:																								
Phone:										Cell:										Email:														

Reason for Referral: - concerns - diagnosis - situation - symptoms - risk to self/others																													
Medications (list or attach all current medications):																													
Supportive Housing requested?					<input type="checkbox"/> No					<input type="checkbox"/> Yes					Vocational Supports requested?					<input type="checkbox"/> No					<input type="checkbox"/> Yes				
Referral Source Name:										Billing #:																			
Professional Designation:										Email:																			
Agency Name and Office Mailing Address: <small>(affix sticker or stamp)</small>										Phone:										Fax:									

Before faxing clinical information, please ensure fax number (905-795-1129) is automatically programmed into your equipment.

This facsimile (fax) transmission is confidential, may contain legally privileged information and is intended for the review by only the individual or party to whom it is addressed, and for no one else. If it is received by someone other than the intended recipient, any dissemination, distribution or copy of this fax transmission is strictly prohibited. Please notify us immediately by phone and return the fax transmission to us by mail. We are compliant with current privacy legislation. We collect personal information for clinical service coordination assessment and treatment, research, and legal and regulatory purposes.

We Ask Because We Care

Mental Health and Addictions providers in Brampton, Bramalea, Bolton/Caledon, Dufferin County, North Etobicoke, Malton, and west Woodbridge (the Central West LHIN) are collecting social information from individuals seeking service to find out who we serve and what are the unique needs amongst these individuals. We will also use this information to understand people's experiences and outcomes.

1. *Do I have to answer all the questions?* No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

2. *Who will see this information?* This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other individuals and no one will be able to identify any of the individuals seeking service.

What language would you feel most comfortable speaking in with your health care provider? Choose ONE.				
<input type="checkbox"/> Amharic	<input type="checkbox"/> English	<input type="checkbox"/> Korean	<input type="checkbox"/> Somali	<input type="checkbox"/> Urdu
<input type="checkbox"/> Arabic	<input type="checkbox"/> Farsi	<input type="checkbox"/> Nepali	<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> ASL	<input type="checkbox"/> French	<input type="checkbox"/> Polish	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Bengali	<input type="checkbox"/> Greek	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tamil	
<input type="checkbox"/> Chinese (Cantonese)	<input type="checkbox"/> Hindi	<input type="checkbox"/> Punjabi	<input type="checkbox"/> Tigrinya	<input type="checkbox"/> Do not know
<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Russian	<input type="checkbox"/> Turkish	<input type="checkbox"/> Prefer not to answer
<input type="checkbox"/> Czech	<input type="checkbox"/> Italian	<input type="checkbox"/> Serbian	<input type="checkbox"/> Twi	
<input type="checkbox"/> Dari	<input type="checkbox"/> Karen	<input type="checkbox"/> Slovak	<input type="checkbox"/> Ukrainian	
Were you born in Canada?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know	<input type="checkbox"/> Prefer not to answer	
If not born in Canada, what year did you arrive?				
<input type="checkbox"/> Please check if the year provided is a guess/estimate				
Which of the following best describes your racial or ethnic group? Choose ONE.				
<input type="checkbox"/> Asian - East (e.g. Chinese, Japanese, Korean)	<input type="checkbox"/> Latin American (e.g. Argentinean, Chilean, Salvadoran)			
<input type="checkbox"/> Asian - South (e.g. Indian, Pakistani, Sri Lankan)	<input type="checkbox"/> Metis			
<input type="checkbox"/> Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	<input type="checkbox"/> Middle Eastern (e.g. Egyptian, Iranian, Lebanese)			
<input type="checkbox"/> Black - African (e.g. Ghanaian, Kenyan, Somali)	<input type="checkbox"/> White - European (e.g. English, Italian, Portuguese, Russian)			
<input type="checkbox"/> Black - Caribbean (e.g. Barbadian, Jamaican)	<input type="checkbox"/> White - North American (e.g. Canadian, American)			
<input type="checkbox"/> Black - North American (e.g. Canadian, American)	<input type="checkbox"/> Mixed heritage (e.g. Black - African & White - North American)			
<input type="checkbox"/> First Nations	Please specify: _____			
<input type="checkbox"/> Indian - Caribbean (e.g. Guyanese with origins in India)	Other(s): Please specify: _____			
<input type="checkbox"/> Indigenous/Aboriginal - not included elsewhere	<input type="checkbox"/> Do not know			
<input type="checkbox"/> Inuit	<input type="checkbox"/> Prefer not to answer			
What is your sexual orientation? Choose ONE.				
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Lesbian	
<input type="checkbox"/> Queer (a term used by people who do not follow common sexual orientations)		<input type="checkbox"/> Do not know	<input type="checkbox"/> Prefer not to answer	
<input type="checkbox"/> Two-Spirit (a term used by Aboriginal people)	<input type="checkbox"/> Other (Please specify): _____			
What was your total family income before taxes last year? Choose ONE.				
<input type="checkbox"/> Do not know	<input type="checkbox"/> Prefer not to answer			
<input type="checkbox"/> \$0 - \$14,999	<input type="checkbox"/> \$20,000 – \$24,999	<input type="checkbox"/> \$30,000 – \$34,999	<input type="checkbox"/> \$40,000 – \$59,999	
<input type="checkbox"/> \$15,000 – \$19,999	<input type="checkbox"/> \$25,000 – \$29,999	<input type="checkbox"/> \$35,000 – \$39,999	<input type="checkbox"/> \$60,000 or more	
How many people does this income support?				
<input type="checkbox"/> Do not know		<input type="checkbox"/> Prefer not to answer		



SHIP
HOUSING APPLICATION

HOUSING APPLICATION SECTION

This section must be completed by your **PSYCHIATRIST or FAMILY DOCTOR** who is actively managing your treatment. If this is completed by a Mental Health Professional, SHIP will obtain verification from your Doctor, Psychiatrist or Health Records.

Mental Health and/or Addictions Diagnoses: _____

- Dual Diagnosis** Yes No
- Substance Use Issues** Alcohol Drugs Gambling Not Applicable
- Suicide Attempt in the past 2 years** Yes No If yes, date of last attempt: _____
- Self-Harm behaviour in the past 2 years** Yes No If yes, date of last incident: _____
- Issue with aggression or anger** Yes No Explain: _____
- Fire Setting/Careless Smoking** Yes No Explain: _____
- Sexually inappropriate behaviour** Yes No If yes, date of last incident: _____
- Recent Mental Health hospitalization** Yes No **Currently on CTO** Yes No
- Level of case management support required** Minimum Moderate High
- Age of Onset of Mental Illness** _____ **Age of First Psychiatric Hospitalization** _____

Doctor's Stamp or Signature **Doctor's Name (please print)** **Month** **Day** **Year**

Have you had any Criminal Offences in the past one (1) Year Yes If YES, complete below: No

PRESENT STATUS WITH THE JUSTICE SYSTEM

- | | | |
|---|--|---|
| <input type="checkbox"/> Stay of Proceedings | <input type="checkbox"/> Restraining Order | <input type="checkbox"/> Conditional Sentence |
| <input type="checkbox"/> Court Diversion | <input type="checkbox"/> Charges withdrawn | <input type="checkbox"/> Custodial Sentence |
| <input type="checkbox"/> On Bail-Awaiting Trial | <input type="checkbox"/> Peace Bond | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Awaiting Sentence | <input type="checkbox"/> Conditional Discharge | <input type="checkbox"/> Ontario Review Board |
| <input type="checkbox"/> Incarcerated | <input type="checkbox"/> Time Served | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Unfit to Stand Trial | | |

Please note: the above information will not be used against you in your housing application. This information will help to determine if you are eligible for the Supportive Housing option with the Mental Health and Justice program.

Name of Parole/Probation Officer: _____	Organization _____	Number: _____ () -
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HOUSING APPLICATION

SUPPORTIVE HOUSING OPTIONS

Housing locations chosen **must** be within the region of your supports (family, case worker, doctors, etc)

Independent Living Units: Location(s) Preference (indicate 1st and 2nd location choice):

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Mississauga | <input type="checkbox"/> Etobicoke/York |
| <input type="checkbox"/> Brampton | <input type="checkbox"/> Caledon |
| <input type="checkbox"/> Malton | <input type="checkbox"/> Orangeville |

Transitional Housing

- | | |
|--|---|
| <input type="checkbox"/> Hammond House – Mississauga
(8 residents per home – 1 room per resident) | <input type="checkbox"/> Parsons Place – Brampton
(8 residents per home – 1 room per resident) |
| <input type="checkbox"/> Peace Ranch – Farm (located in Caledon - 10 residents / 1 room per resident – MUST have a diagnosis of Schizophrenia and be 18 – 65 years of age) | |
| <input type="checkbox"/> Peace Ranch – Townhome (located in Brampton - shared accommodation 4 residents / 1 room per resident) | |

Do you require a wheelchair accessible unit or have any accommodation needs: Yes No Describe: _____

HOUSEHOLD MEMBERS

(include only those who will reside **with** you) Copy of Citizenship or Immigration status must be provided for **each** member

- | | | |
|---|--|------------------------------|
| 1. _____
Last Name First Name Middle | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | _____
Date of Birth D/M/Y |
| 2. _____
Last Name First Name Middle | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | _____
Date of Birth D/M/Y |
| 3. _____
Last Name First Name Middle | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | _____
Date of Birth D/M/Y |

Do you have custody of the children? Yes No

CURRENT LIVING SITUATION

- | | |
|--|---|
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Living with family or friend but would like to live independently |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Own Home |
| <input type="checkbox"/> No Fixed Address | <input type="checkbox"/> Renting with no risk of losing housing |
| <input type="checkbox"/> At risk of losing housing | <input type="checkbox"/> Evicted from housing (must submit copy of Eviction Notice) |

What is your monthly rent amount? (submit copy of recent rent receipt if applicable) \$ _____

Have you previously LIVED in SHIP or Peace Ranch housing? Yes No

APPLICANT INCOME

- | | | | | |
|---|---|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Ontario Works | <input type="checkbox"/> ODSP | <input type="checkbox"/> CPP | <input type="checkbox"/> Retirement Pension | <input type="checkbox"/> LTD |
| <input type="checkbox"/> Old Age Security | <input type="checkbox"/> Child Support | <input type="checkbox"/> Alimony | <input type="checkbox"/> Employment Insurance | <input type="checkbox"/> Student Loan |
| <input type="checkbox"/> Part time employment | <input type="checkbox"/> Full time employment | <input type="checkbox"/> No Income | <input type="checkbox"/> Other (specify) _____ | |

HOW MANY MEMBERS OF YOUR HOUSEHOLD CONTRIBUTE TO THE HOUSEHOLD INCOME: 1 2 3 4 5
(Submit copy of income verification copies of each household member that will be residing with you)

TOTAL MONTHLY HOUSEHOLD INCOME (submit copies of recent income statements) \$ _____

HIGHEST LEVEL OF EDUCATION

- | | | |
|---|---|--|
| <input type="checkbox"/> Some Elementary / Junior High School | <input type="checkbox"/> Some Secondary / High School | <input type="checkbox"/> Some College / University |
| <input type="checkbox"/> Elementary / Junior High School | <input type="checkbox"/> Secondary / High School | <input type="checkbox"/> College / University |
| <input type="checkbox"/> No Formal Schooling | <input type="checkbox"/> Other: _____ | |



SHIP

Your Consent to Share Information

Central Intake is funded by the Ministry of Health and Long Term Care and administered by Services and Housing In the Province (SHIP). It provides access to the housing and support services of SHIP as well as partnering agencies in the Region of Peel, Etobicoke/York and the County of Dufferin. The partners in this initiative include Reconnect, CMHA – Peel/Dufferin, INDUS, Trillium health Partners, PAARC, Kerrys Place, BCCL and Family Transition Place.

To qualify for supportive housing, you must give Services and Housing In the Province consent:

1. To receive or access psychiatric and hospital records that give information on your diagnosis and past mental health hospitalizations. You must submit a signed, witnessed, and dated Consent Form to obtain records from a doctor, psychiatrist or hospital.
2. To share information, including psychiatric, hospital or other external records, on an as-needed basis within and between the partnering agencies for the purpose of intake and, possibly, appeal services.
3. To telephone you and leave voice mail at the locations you designate in the application form.
4. To further determine your telephone number, location or continuing interest in service through the contact of persons you designate. Please do not include the names of family, friends, or workers that you do not wish us to call.
5. To continue this agreement until the intake service is completed or you no longer want service.

Privacy Statement

SHIP respects your privacy. The confidentiality of your personal health information is maintained through the consistent application of strict policies and procedures that are consistent with the requirements of current legislation. Your consent is required for your personal health information to be used for your care by SHIP staff or shared with anyone other than SHIP staff, where Ontario's privacy legislation allows. SHIP staff are available to explain our policy with regard to confidentiality.

Important Note

It is the policy of Central Intake to fully respect each applicant's confidentiality. However, there are limitations on our ability or obligations to maintain confidentiality, Central Intake is required to share information to the partnered agencies involved with determining eligibility for Supportive Housing, when your behaviour poses a threat of physical harm to yourself or someone else, or other legally required reporting situations.

Your name (first/last): _____ Birth date (M/D/Y): _____

Your signature: _____ Date (M/D/Y): _____

APPLICANT CHECKLIST

- Please review the items below and ensure that they are included with your application or at time of assessment.
- Consent to Disclose Personal Health Information -- MUST BE ORIGINALS** -- (signed and dated - Doctor, case manager, family member who are permitted to discuss applicant's information for the sole purpose of application)
 - Substitute Decision Maker (SDM), Public Guardian & Trustee and/or CTO documentation** (if applicable)
 - Rental Receipt** (if paying rent)
 - Eviction Notice** (where applicable)
 - Income Receipt** (most recent)
 - Copy of Citizenship, Landed Immigrant Status, Birth Certificate** (for all potential household members)
 - Custody Agreements** (if requesting additional bedrooms because you have legal custody/visitation rights, copy of the agreement must be attached)



SHIP

**Consent to the Collection, Use and Disclosure
of Personal Health Information**

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

SHIP is seeking your consent for it to collect, use and/or disclose your personal health information.

Personal health information (PHI) is the information that health care providers (e.g., doctors, hospitals, etc.) collect about you and use to provide you with health care. PHI includes information about:

- your physical health and mental health;
- your health history;
- your family health history;
- the health care you have received;
- your health card number; and
- name of your substitute decision-maker.

What is “collection, use or disclosure” under PHIPA?

“Collection” occurs when SHIP obtains PHI about you in any form (eg. verbal or written) and from any source including family and friends for the purposes outlined in the consent form.

“Use” refers to SHIP using the PHI they have regarding you. For instance, information in your record may be used to develop a Service/Care Plan for you.

“Disclosure” occurs when the information in the possession of SHIP is shared with another health information custodian or a non-health information custodian. For example, SHIP may disclose information to a community program you will be attending.

SHIP will only collect, use and disclose your personal health information with your consent unless a particular collection, use or disclosure is permitted or required by law without your consent.

You can refuse to sign this consent form or withdraw your consent at any time by writing to:

Privacy Officer
Supportive Housing In Peel
107 – 969 Derry Road East,
Mississauga, Ontario
L5T 2J7



Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Completed by: Client
 SDM*

I, _____, authorize _____
(Print name of client or SDM) *(Print name of organization e.g., doctor, psychiatrist, hospital)*

to disclose my personal health information consisting of: **Health Records pertaining to a mental health illness diagnoses or an addiction**

(Describe in as much detail as possible the personal health information to be disclosed)

Print the contact information of the person/organization requiring the information:

Department: CENTRAL INTAKE

Organization: **SHIP**

Address: 969 Derry Road East, Mississauga, ON, L5T 2J7

I understand that the purpose of disclosing my personal health information to the person or organization noted above is to assist in providing me with health care. I understand that I can refuse to sign this consent form or later withdraw my consent.

Name: _____

Signature: _____

Date of Birth: _____
(MM/DD/YYYY)

Date: _____

Witness Name: _____

Signature: _____

Date: _____

Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.