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

Referral Source Name:		Billing #:	
Professional Designation:		Email:	
Agency Name and Office Mailing Address: *(affix sticker or stamp)*		Phone:	
		Fax:	

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

February 2017

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.

☐ Amharic	☐ English	☐ Korean	☐ Somali	☐ Urdu
☐ Arabic	☐ Farsi	☐ Nepali	☐ Spanish	☐ Vietnamese
☐ ASL	☐ French	☐ Polish	☐ Tagalog	☐ Other (specify):
☐ Bengali	☐ Greek	☐ Portuguese	☐ Tamil	_____
☐ Chinese (Cantonese)	☐ Hindi	☐ Punjabi	☐ Tigrinya	☐ Do not know
☐ Chinese (Mandarin)	☐ Hungarian	☐ Russian	☐ Turkish	☐ Prefer not to answer
☐ Czech	☐ Italian	☐ Serbian	☐ Twi	
☐ Dari	☐ Karen	☐ Slovak	☐ Ukrainian	

Were you born in Canada? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

If not born in Canada, what year did you arrive? ☐ Please check if the year provided is a guess/estimate

Which of the following best describes your racial or ethnic group? Choose ONE.

☐ Asian - East (e.g. Chinese, Japanese, Korean)	☐ Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ Asian - South (e.g. Indian, Pakistani, Sri Lankan)	☐ Metis
☐ Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ Black - African (e.g. Ghanaian, Kenyan, Somali)	☐ White - European (e.g. English, Italian, Portuguese, Russian)
☐ Black - Caribbean (e.g. Barbadian, Jamaican)	☐ White - North American (e.g. Canadian, American)
☐ Black - North American (e.g. Canadian, American)	☐ Mixed heritage (e.g. Black - African & White - North American)
☐ First Nations	Please specify: _____
☐ Indian - Caribbean (e.g. Guyanese with origins in India)	☐ Other(s): Please specify: _____
☐ Indigenous/Aboriginal - not included elsewhere	☐ Do not know
☐ Inuit	☐ Prefer not to answer

What is your sexual orientation? Choose ONE. ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian

☐ Queer (a term used by people who do not follow common sexual orientations) ☐ Do not know ☐ Prefer not to answer

☐ Two-Spirit (a term used by Aboriginal people) ☐ Other (Please specify): _____

What was your total family income before taxes last year? Choose ONE. ☐ Do not know ☐ Prefer not to answer

☐ $0 - $14,999	☐ $20,000 – $24,999	☐ $30,000 – $34,999	☐ $40,000 – $59,999
☐ $15,000 – $19,999	☐ $25,000 – $29,999	☐ $35,000 – $39,999	☐ $60,000 or more

How many people does this income support? ☐ Do not know ☐ Prefer not to answer

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

- ☐ Stay of Proceedings
- ☐ Court Diversion
- ☐ On Bail-Awaiting Trial
- ☐ Awaiting Sentence
- ☐ Incarcerated
- ☐ Unfit to Stand Trial
- ☐ Restraining Order
- ☐ Charges withdrawn
- ☐ Peace Bond
- ☐ Conditional Discharge
- ☐ Time Served
- ☐ Conditional Sentence
- ☐ Custodial Sentence
- ☐ Probation
- ☐ Ontario Review Board
- ☐ Other:_____

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:** ( ) -

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)*:

- ☐ Mississauga
- ☐ Brampton
- ☐ Malton
- ☐ Etobicoke/York
- ☐ Caledon
- ☐ Orangeville

Transitional Housing

- ☐ Hammond House – Mississauga (8 residents per home – 1 room per resident)
- ☐ Parsons Place – Brampton (8 residents per home – 1 room per resident)
- ☐ 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)
- ☐ 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. _____ _____ _____ ☐ Male ☐ Female ☐ Other _____
   Last Name *First Name* *Middle* *Date of Birth* D/M/Y
2. _____ _____ _____ ☐ Male ☐ Female ☐ Other _____
   Last Name *First Name* *Middle* *Date of Birth* D/M/Y
3. _____ _____ _____ ☐ Male ☐ Female ☐ Other _____
   Last Name *First Name* *Middle* *Date of Birth* D/M/Y

Do you have custody of the children? ☐ Yes ☐ No

CURRENT LIVING SITUATION

- ☐ Shelter
- ☐ Living with family or friend but would like to live independently
- ☐ Own Home
- ☐ Renting with no risk of losing housing
- ☐ Hospital
- ☐ No Fixed Address
- ☐ At risk of losing housing
- ☐ 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

- ☐ Ontario Works
- ☐ ODSP
- ☐ CPP
- ☐ Retirement Pension
- ☐ LTD
- ☐ Old Age Security
- ☐ Child Support
- ☐ Alimony
- ☐ Employment Insurance
- ☐ Student Loan
- ☐ Part time employment
- ☐ Full time employment
- ☐ No Income
- ☐ 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

- ☐ Some Elementary / Junior High School
- ☐ Some Secondary / High School
- ☐ Some College / University
- ☐ Elementary / Junior High School
- ☐ Secondary / High School
- ☐ College / University
- ☐ No Formal Schooling
- ☐ Other: _____

Your Consent to Share and Collect Information

Central Intake 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, Kerry's Place, BCCL and Family Transition Place.

To qualify for supportive housing, SHIP requires consent:

1. To receive or access psychiatric and hospital records that give information on your diagnosis and past mental health hospitalizations. These may be accessed through regional and provincial systems (e.g., IAR, HPG, Catalyst, ConnectingOntario) or through 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.

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

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

Important Information:

- We take steps to protect your PI/PHI from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.
- We conduct audits and complete investigations to monitor and manage our privacy compliance.
- We take steps to ensure that everyone who performs services for us protects your privacy and only use your PI/PHI for the purposes to which you have consented.

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
Services and Housing In the Province
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.