PROGRAM ELIGIBILITY CRITERIA

A. ESSENTIAL CRITERIA

Individual:

1. Has been diagnosed with a severe and persistent mental illness.
2. Is a resident of Ottawa
3. Is 16 years of age or over. (Youth may have special agreements with CAS.)
4. Has had frequent breakdowns in community living (e.g., has been hospitalized).
5. Has or may suffer a breakdown in community living because of functional limitations.
6. Has one of the following **Service Needs**:
    - Requires assistance to use resources appropriately. Client may be overusing or under using services so that needs are not being met.
    - Requires help to access services.
    - Assistance/support to accept needed services.

Ministry of Health Definition

- **Diagnosis** such as schizophrenia, major affective disorders, personality disorders, paranoid and other psychoses should be present **or** person demonstrates a pattern of behaviours that indicate a severe and persistent mental illness.
- **Disability** refers to the fact that the disorder interferes with the person's capacity to organize and complete the activities of daily living.
- **Duration** may be based on a **severe** first episode or a chronic nature of the illness

7. Has one or more of the following **Support Needs**:
    - Is isolated without social or family support
    - Lacks professional support
    - Family support is problematic, in jeopardy, or absent
    - Functional impairment in more than one skill area: daily living, social, educational, vocational

B. DESIRABLE (These indicators are not essential but reinforce the need for case management.)

- Acknowledgement by client of need for support
- Acknowledgement by client of need to develop or maintain a network
- Is homeless or at risk of becoming homeless
- Has other complex needs.

C. ADDITIONAL CRITERIA (These indicators may also reinforce the need for support services.)

- Loss of major supports (i.e., family) anticipated.
- Service is needed to maintain recent rehabilitation gains (i.e., from supportive housing or hospital services).
- Individual has multiple problems which require coordination, bridging across and between service systems.
- Presence of concurrent disorder
- Presence of a dual diagnosis

Mental Health Community Support Services

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Office Use Only
☐ *Intake*
☐ *Re-assessment*
☐ *Agency*_____

Eligibility Referral Form

Former client of CMHA or other agency (eg. Salus, SWCHC, etc): ☐ Yes ☐ No

If yes, please list which agency: _____

Client (full name): **DOB (m/d/y):** **Age:**

Do you identify as Inuit/Metis/First Nations: ❑Yes ❑No **Do you identify as a Veteran**: ❑Yes ❑No

Gender: ❑ Male ❑ Female ❑ Transgendered ❑ Prefer not to disclose

Address: **Telephone #:**

Postal Code: **Email:**

Person completing the Form:

Referral Source (name and address or agency): **Telephone #:**

Emergency Contact: **Telephone #:**

Determinants for Service (Priority indicators of SMI – please indicate diagnosis):

PRIMARY MENTAL HEALTH DIAGNOSIS: ☐Schizophrenia ☐Mood Disorder ☐Anxiety Disorder ☐ Active substance use
List medications: *(list all substances abused)*

☐ person has severe episodes of illness, is severely disabled as a result of their illness and unwilling/unable to engage/follow-up with treatment plans without significant community mental health support
☐ psychotic symptoms/ past episodes of aggressive or violent behavior
☐ **Psychiatrist**: _____ **Phone #:** _____

SECONDARY MENTAL HEALTH DIAGNOSIS (e.g. Personality disorder, developmental delay, etc.) (Please list):

☐ Dual Diagnosis
☐ Personality Disorder co-existing with Primary mental health diagnosis.

GENERAL MEDICAL CONDITIONS (Please list all medical conditions):
☐ Tobacco Use
☐ Medical conditions requiring support to maintain treatment, requiring education, requiring motivation to engage in regular treatment and MH
☐ No GP ☐ Family Doctor: _____ Phone #: _____
☐ Pharmacy: _____ Phone #: _____
☐ Health Card # _____ Version code _____ Expiration date: _____

PSYCHOSOCIAL AND ENVIRONMENTAL LIFE DOMAINS
☐ Demonstrated extensive outstanding psycho social needs in life domain areas. **Support cannot be provided by other agencies/services.**

PLEASE INDICATE AND LIST SPECIFIC OUTSTANDING PROBLEMS OR ISSUES RELATED TO CLIENT IN THE FOLLOWING AREAS:

Primary support group: ❑ **Problems with primary support group:**	**Who does client have around? Friends/family (please identify any supports)** □ Impoverished social / family circle □ Domestic abuse

Social Environment: ❑ **Problems related to social environment:**	**What does client do in spare time (please list activities if available)** □ Limited/non-existent daily activities, recreational activities
Educational Background / Occupational History : ❑ **Educational problems:** **Highest Level of education:**_____ ❑ **Occupational problems:** **Last worked:**_____	**Level of education attained / specific training received /Job experience** □ Unfulfilled education goals □ Requires support to set/implement educational goals □ Literacy issues □ Unfulfilled occupational goals □ Requires support to set/implement occupational goals □ Interest in working □ Interest in returning to school □ Interested in volunteering
Current Housing situation: Indicate current housing costs/rent: ❑ **Housing problems:** ❑ **Registry Application Complete:** ❑ Yes ❑ No **# days in shelter or homeless (within last 2 years):** _____	**Where does client live?** □ Long term/frequent homelessness and/or □ Unable to maintain housing, recently evicted □ Difficulty with activities of daily living
Current source of income and amount: ❑ **Financial problems:** ❑ ODSP _____ ❑ Ontario Works_____ ❑ Other _____	□ Difficulty accessing and maintaining benefits. □ Problems budgeting.
Current and past Hospitalizations: (including ER visits) ❑**Meets criteria for ACT referral** ❑**Person responsible for ACT referral:**_____ **# days of hospitalization (within last 2 years):** _____ **# of ER visits in the past year:** _____ **# of ER visits in the past 30 days:** _____ **List dates and Hospital (of both) if available:**_____ _____ _____	□ 3 or more psychiatric hospitalizations □ 50 days or more of hospitalizations within last year □ 150 days or more of hospitalizations within last 3 years □ Over/under use of health care services □ Problems following-up with recommended treatment plans □ CTO □ Yes □ No □ **Date Issued: _____ Expiry: _____** □ Suicidal thoughts or attempts_____ (Current/Past)
❑ **Problems with the criminal justice system** **Probation Officer:** _____ **Current charges:** _____ **Next Known Court Date:** _____ **Lawyer:** _____ **Phone #:** _____	□ Subject of two or more police complaints/interventions within the last 12 months □ Has been incarcerated in a correctional facility for 30 or more days within this period □ NCR if so, disposition :_____ □ ORB date of next ORB: _____

Other Services involved (e.g. Salus, The Royal, etc): ☐ Yes (please specify)_____ ☐ No

What service are you requesting?	❑ **Outreach Service**	❑ **MHCSS Referral**	❑ **ACTT**

Rationale for referral: (**mandatory** in order for the application to be processed)

❑ **Preferred primary language of client:**_____ ❑ **Preferred gender of worker :** _____

Worker Completing Form:_____ **Date Form Completed:**_____

(signature)

Consent:

We require consent from the potential client to allow **CMHA Ottawa Branch** to collect and store the information provided in this form. Please include a signed "Consent to Collection, discussion and disclosure of Personal Health Information" form. If written consent is not possible, please obtain verbal consent. Indicate such by including your signature on the Consent form, along with a second witness.

** ***Referrals received without the above consent and/or missing Primary mental health diagnosis and rationale will not be accepted into services***

Consent form attached, signed by the potential client: ☐**yes** ☐ **no**

Consent form attached, signed by two witnesses of verbal consent: ☐ **yes** ☐ **no**

OFFICE USE ONLY

Date Received: _____ *Was Accepted into service: ☐ Yes ☐ No*

If not accepted list reason and if referred elsewhere: _____

Canadian Mental Health Association
Ottawa
Mental health for all

Association canadienne pour la santé mentale
Ottawa
La santé mentale pour tous

1355 Bank Street, Suite 301
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Tel: (613) 737-7791
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Consent to the collection, discussion and disclosure of Personal Health Information for the purpose of receiving community mental health support services

I _____(name, date of birth), consent for the Canadian Mental Health Association, Ottawa Branch, to collect, discuss with and disclose my personal health information to the Mental Health Community Support Services (MHCSS) listed below and to the Assertive Community Treatment (ACT) program that I have checked off for the purpose of determining who might provide me with community mental health support.

✓	**MHCSS**	✓	
	Canadian Mental Health Association		Ottawa Salus Corporation
	Sandy Hill Community Health Centre		Upstream Ottawa
	Montfort Renaissance		The Royal Mental Health – Care & Research
	Pinecrest-Queensway Health and Community Services		Somerset West Community Health Centre
	ACTT Program		

I also hereby authorize _____ (name of person or agency) to disclose to the Canadian Mental Health Association, Ottawa Branch, my relevant personal health information.

I consent to receive community mental health support from the Canadian Mental Health Association, Ottawa Branch in the event it is considered to be an appropriate and available service provider.

I acknowledge being offered a copy of "How CMHA Ottawa Branch Collects and Protects Your Personal Health Information."

I am aware that I can refuse to give my consent and not receive services. I am also aware that I can change or cancel my consent at any time.

I further authorize upon subsequent verbal consent for the Canadian Mental Health Association to discuss my situation and disclose my personal health information to the extent that it is necessary with individuals and organizations for the purpose of advocating on my behalf prior to being accepted into an MHCSS or ACT program.

Date: _____

Signature: _____

Witness: _____

Witness (a second witness is required to verify verbal consent is given):_____