Mental Health Community Support Services (MHCSS)

PROGRAM ELIGIBILITY CRITERIA

Mental Health Community Support Services (MHCSS) is a partnership of six agencies that provide intensive case management supports to individuals living with severe and persistent mental illness who require support in order to live in the community.

A. ESSENTIAL CRITERIA

Individual:

1. Has been diagnosed with a severe and persistent mental illness.
2. Is a resident of Ottawa, Ontario.
3. Is 16 years of age or older.
4. Is less than 64 years old – please refer to Geriatric Psychiatry Community Services of Ottawa.
5. Has had frequent interruptions in community living (frequent hospitalization, homelessness).
6. Has or may suffer an interruption in community living because of functional limitations.
7. 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.
8. 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 several areas: daily living skills, social skills, educational/vocational, financial.
   - Individual has multiple problems that require coordination, bridging across and between service systems.

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

B. SECONDARY CRITERIA (These indicators are not essential but reinforce the need for intensive 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.
- Imminent loss of major supports (i.e. family).

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

- Anticipated loss of major supports (i.e. family).
- Service is needed to maintain recent rehabilitation gains (i.e. from supportive housing or hospital services).
- Presence of concurrent disorders.
- Presence of a dual diagnosis.

PLEASE BE ADVISED THAT THE WAIT LISTS FOR CASE MANAGEMENT SERVICES ARE SIGNIFICANTLY LENGTHY

Canadian Mental Health Association Ottawa Mental health for all | Association canadienne pour la santé mentale Ottawa La santé mentale pour tous | SALUS Montfort Renaissance | UPSTREAM Ottawa | Sandy Hill Community Health Centre / Centre de santé communautaire Côte-de-Sable | Somerset West Community Health Centre

Mental Health Community Support Services

301—311 McArthur Avenue
Ottawa, ON K1L 8M3 Tel: 613-737-7791
Fax: 613- 737-7644 TDD: 613-737-9480
Email: general@cmhaottawa.ca

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

Eligibility Referral Form

Have you ever received services from an MHCSS agency? ☐ Yes ☐ No

If yes, please list which agency and when:_____

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 ❑Transgender ❑ Prefer not to disclose ❑ Other _____

Preferred pronoun: **Primary language:**

Address: **Telephone #:**

Postal Code: **Email:**

Person completing the form:

Referral source (name and agency): **Telephone #:**

Emergency contact (please also add to consent form): **Telephone #:**

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

PRIMARY MENTAL HEALTH DIAGNOSIS: __Schizophrenia __Mood Disorder __Anxiety Disorder __Active substance use

☐ 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

☐ Past or recent episodes of aggressive or violent behavior _____
☐ Level of risk: Low_____ Moderate_____ High_____
☐ Competent to make treatment decisions: Yes ___ No___
☐ SDM? Name _____ Number _____ Relationship _____

☐ Psychiatrist: _____ Phone #: _____

List medications or attach MAR sheet:

List any substances used and frequency of use :

Has treatment for substance use been pursued? Where? When?

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

☐ Dual Diagnosis: Are you eligible for DSO-ER? · Yes · No · Don't know · Already connected to DSO-ER

☐ Personality disorder co-existing with primary mental health diagnosis: _____

GENERAL MEDICAL/PHYSICAL HEALTH CONDITIONS (Please list all medical conditions):

☐ Medical conditions requiring support to maintain treatment, requiring education, requiring motivation to engage in regular treatment
☐ Tobacco use
☐ No GP
☐ Family doctor: _____ Phone #: _____
☐ Pharmacy: _____ Phone #: _____

PSYCHOSOCIAL AND ENVIRONMENTAL LIFE DOMAINS: Where 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: Current situation:	**Who does the person have around? Friends/family (please identify any supports)** □ Impoverished social/family circle □ Domestic abuse □ Requires support related to child care □ CAS involvement
Social Environment: □ Problems related to social environment: Current situation:	**What does the person do in their 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:** □ **Housing Registry Application Complete:** · Yes · No # days in shelter or homeless (within last two years):_____	**Where does client live?** □ Long term/frequent homelessness and/or □ Unable to maintain housing, recently evicted □ Difficulty with activities of daily living
Source of income/amount: □ ODSP $_____ □ Ontario Works $_____ □ Other $_____ □ Financial problems:	□ Financially capable? Yes ____ No _____ □ Substitute Decision Maker? _____ □ Public Guardian and Trustee _____
Current and past Hospitalizations: (including ER visits) # 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**:**_____ _____ _____ _____ □ Suicidal ideation or attempts _____ □ Current _____ □ Past _____	□ Three 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: _____ Issuing physician: _____ Meets criteria for ACTT referral? _____ ACTT referral completed?_____
Involvement with the criminal justice system Probation Officer: _____ Phone #: _____ 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 currently involved (e.g. CAS, YSB, The Royal, etc.): ▪ Yes (please specify)______________________________

Rationale for Case Management Referral: (**Mandatory in order for the application to be processed**)
Please indicate the individuals' current needs and goals requiring support.

Preferred gender of worker: ___________________________

Person 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 the signed "Consent to Collection, discussion and disclosure of Personal Health Information" form attached.

****Referrals received without consent, missing primary mental health diagnosis and/or rationale for referral will NOT be processed. ****

****Please ensure to keep us updated with any changes in contact information while awaiting services****

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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

301—311 McArthur Avenue
Ottawa, Ontario K1L 8M3
Tel: (613) 737-7791
Fax: (613) 737-7644
TDD: 613-737-9480

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) partners and/or to the Assertive Community Treatment Team (ACTT) centralized access for the purpose of determining the most appropriate community mental health support service for me.

Please add emergency contact and any other agencies you wish to provide consent to for the sharing of information for proper assessment.

✓	Canadian Mental Health Association	✓	Somerset West Community Health Centre
✓	Ottawa Salus Corporation	✓	Sandy Hill Community Health Centre
✓	Montfort Renaissance	✓	ACTT centralized access
✓	Upstream Ottawa	✓	LHIN / Health Links
✓		✓	

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 further authorize, upon subsequent verbal consent, for the Canadian Mental Health Association to discuss my referral and personal health information, when deemed necessary, for the purpose of advocating on my behalf prior to being accepted into MHCSS.

I agree to be contacted by email, should my phone number no longer be valid, with the understanding that email is not safeguarded on the Branch message system and that the Branch cannot guarantee the privacy or security of the messages that I or they send or receive. I understand that email can be unintentionally misdirected, and that the true identity of the sender or receiver cannot be identified, and that it is impossible to ensure that only the recipient can read the message once it has been sent. _____*(Initial here)*

I consent to receive community mental health support and 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 and that I can withdraw my consent to communicate by email message at any time.

Signature of person being referred: _____

Date: _____

Witness: _____(if only verbal consent obtained)