

PROGRAM ELIGIBILITY CRITERIA

A. ESSENTIAL CRITERIA

Individual:

1. Appears to have 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.
 - Advocacy to change service criteria in order to serve the individual, or to develop a new resource for the client.
 - Assistance/support to accept needed services.
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.

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

- Acknowledgement by client of need for support within a six month period of engagement.
- Acknowledgement by client of need to develop or maintain a network.
- Need for a service is urgent at time client is being considered.
- 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 (e.g., 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

Check only one please:

- Ottawa Assertive Community Treatment Teams
OR
- Mental Health Community Support Services

REFERRAL FORM

Date of referral (D/M/Y) : _____

SECTION I: Client information

1) Demographic data

Last name : _____ First name : _____ Marital Status : _____

Date of birth (D/M/Y) : _____ Sex : F M

Address : _____

Telephone : (____) _____ Source of income : _____

Language preference : English French Other : _____

2) How does client describe his/her RACE:

- African
- South Asian (Punjabi, Bengali, Gujerati, Tamil, etc.)
- West Asian (Armenian, Iranian, Syrian, Turkish, Palestinian etc.)
- East Asian (Chinese, Vietnamese, Thai, Laotian, Filipino, Japanese, Korean etc.)
- Mixed
- Other
- Prefers not to answer
- Aboriginal

3) Highest level of education achieved:

- No formal schooling
- Some elementary
- Elementary
- Secondary High School
- Some College/University
- College/University
- Unknown

REFERRAL FORM

2) Psychiatric diagnosis and health

Diagnosis : PRIMARY : _____ SECONDARY : _____

Physical problems : _____

Current medications :

NAME	DOSAGE / FREQUENCY

(Continue on extra sheet if needed)

3) Hospitalizations (over past 2 years)

DATE	DURATION	INSTITUTION

(Continue on extra sheet if needed)

4) Homelessness

Dates and duration of homelessness over past 2 years : _____

5) Substance abuse

Does the client struggle with substance abuse? Yes No

If yes, specify _____

6) Functional abilities

	Yes	No
Meets basic needs (housing, food).....	<input type="radio"/>	<input type="radio"/>
Carries out activities of daily living required for basic functioning in the community (ex.: getting to and from places, medical care, personal hygiene).....	<input type="radio"/>	<input type="radio"/>
Maintains safe housing (no eviction or loss of housing).....	<input type="radio"/>	<input type="radio"/>
Maintains vocational activity (school, volunteering, or employment).....	<input type="radio"/>	<input type="radio"/>
Family and/or social network involvement.....	<input type="radio"/>	<input type="radio"/>
History of suicide attempts.....	<input type="radio"/>	<input type="radio"/>
History of harm to others.....	<input type="radio"/>	<input type="radio"/>
Has person been declared financially incompetent.....	<input type="radio"/>	<input type="radio"/>
Does he/she have a Public Guardian and Trustee.....	<input type="radio"/>	<input type="radio"/>
Has person been declared incompetent to make treatment decisions.....	<input type="radio"/>	<input type="radio"/>
Substitute decision maker (name and relationship).....	<input type="radio"/>	<input type="radio"/>

REFERRAL FORM

7) Legal

Dates and duration of incarcerations over past 2 years : _____

Reasons/charges : _____

Other legal problems over past 2 years : _____

Is person under a Community Treatment Order? Yes No

Date of issuance : _____ Issuing physician : _____

Has person been declared Not Criminally Responsible? Yes No

8) Other services involved with client :

NAME	ADDRESS	PHONE NUMBER

***Please ensure Consent to Disclose Personal Health Information for above services are enclosed permitting two-way communication.**

Has this referral and potential assessment been discussed with :

Client	Yes	No
Family	Yes	No
Other (specify) :	_____	

Please include Consent to Disclose Personal Health Information signed by client releasing information to ACT Central Intake & MHCSS from referral source and hospitals involved in the past.

*** Please attach information requested below :

- 1) Discharge summaries of past psychiatric hospitalizations over past 2 years
- 2) Consultation reports or other significant documents within past 2 years
- 3) Consent to Disclose Personal Health Information form

N.B. Please note that all incomplete forms will NOT BE PROCESSED.

S.V.P. Please forward the completed form to the following address :

For intensive case management (MHCSS)

c/o Canadian Mental
Health Association
1355 Bank Street, 3rd floor
Ottawa, Ontario K1H 8K7
Telephone : (613) 737-7791
Fax : (613) 737-7644

For ACT teams

Royal Ottawa Hospital Health Care Group
Intensive Assessment and Intervention Program
Bank Street ACT Team
Att: Intake Coordinator
205-1355 Bank Street
Ottawa, ON K1H 8K7
Telephone (613) 737-7791
Fax: (613) 739-8400

If you do not meet criteria for these programs, you will be given suggestions for other mental health resources.



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.

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.

✓	MHCSS		
	Canadian Hearing Society		Ottawa Salus Corporation
	Canadian Mental Health Association		Project Upstream
	Horizons Renaissance		Royal Ottawa Hospital
	Pinecrest-Queensway Health and Community Services		Somerset West Community Health Centre
	ACT Program		

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):
