

About CMHA-HRB Case Management Programs

The Case Management Programs serve residents of the Halton Region aged 16+ with mental health issues and significant barriers to recovery. Brief descriptions of our programs are provided below. For more information on CMHA-HRB, please visit www.cmhahrb.ca.

Program	Description
Case Management	This case management program assists individuals with <u>significant mental health concerns</u> facing barriers to recovery. Clients are supported with their goals in areas such as life skills, housing, employment, and symptom management.
Dual Diagnosis	This case management program assists individuals with <u>both a developmental disorder and mental health concerns</u> . Clients are supported with their goals in areas such as life skills, housing, employment, and symptom management.

Making a Referral to CMHA-HRB Case Management Programs

- The purpose of the Case Management Programs is to support individuals in the recovery of self-esteem, hope, and personal power. Our programs are suited to those willing to work on goals they believe will give their life meaning.
- Participation in the Case Management Programs is voluntary. **If this is not a self-referral, please discuss this request for service with the person being referred before submitting.**
- In order to facilitate the intake process, we ask that any available clinical reports, records, assessments and summaries be included with the referral.
- Referrals are processed once we receive a completed referral form and written consent allowing us to obtain information from those providing support to the individual being referred. Please ensure that all applicable fields of the referral form are filled in and that a signed consent form is enclosed.

Completed referral forms can be sent to our Milton office:

CMHA-HRB

Attn: Information & Referral Specialist

388 Main Street East, Milton ON, L9T 1P8

Phone: 905-693-4270 ext.2239, Fax: 905-693-9183

A PDF version of this form is available on our website at www.cmhahrb.ca. Go to the **Community Support Programs** menu and click on the "referral forms" link under the "Making a Referral" tab.

**CASE MANAGEMENT PROGRAMS
REFERRAL FORM**

INDIVIDUAL/AGENCY MAKING THE REFERRAL (REFERRAL SOURCE)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Self | <input type="checkbox"/> CMHA-HRB Dual Dx Specialist | <input type="checkbox"/> CMHA-HRB Safe Beds | <input type="checkbox"/> CMHA-HRB Case Management |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> CMHA-HRB Justice Services | <input type="checkbox"/> CMHA-HRB COAST | <input type="checkbox"/> Self via CMHA-HRB Info & Referral Specialist |
| <input type="checkbox"/> External Agency | <input type="checkbox"/> CMHA-HRB CCDP | | |

First Name		Last Name	
Agency & Program			
Position/ Relationship to Applicant			
Address			Unit
City	Province		Postal Code
Contact Number	Fax		
Reason for Referral <i>(attach applicable reports)</i>			
How long have you known the applicant?		Expected Discharge Date <i>(if applicable)</i>	
Will you be continuing to provide support to the applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what capacity?	

INFORMATION ON THE PERSON BEING REFERRED (APPLICANT)

First Name		Last Name	
Date of Birth (M-D-Y)		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Address			Unit/Suite
City	Province		Postal Code
Primary Number <i>(must provide contact number)</i>	<input type="checkbox"/> OK to leave a message identifying CMHA	<input type="checkbox"/> OK to leave a message (do not identify CMHA)	<input type="checkbox"/> Not ok to leave a message
Alternative Number	<input type="checkbox"/> OK to leave a message identifying CMHA	<input type="checkbox"/> OK to leave a message (do not identify CMHA)	<input type="checkbox"/> Not ok to leave a message
Email			

Aboriginal Origins	<input type="checkbox"/> yes <input type="checkbox"/> no	Primary Income	Employed: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> ODSP <input type="checkbox"/> OW <input type="checkbox"/> CPP-D <input type="checkbox"/> Pension <input type="checkbox"/> Other
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Languages Spoken <i>(if Other, please specify)</i>	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other	Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other Specify: _____
Interpreter Required <i>(if Yes, please specify preferred language/dialect)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speaks English	<input type="checkbox"/> Fluently <input type="checkbox"/> Well <input type="checkbox"/> Little <input type="checkbox"/> Not at All
		Reads English	<input type="checkbox"/> Fluently <input type="checkbox"/> Well <input type="checkbox"/> Little <input type="checkbox"/> Not at All
		Writes English	<input type="checkbox"/> Fluently <input type="checkbox"/> Well <input type="checkbox"/> Little <input type="checkbox"/> Not at All
Accessibility/ Special Needs			
Transportation	<input type="checkbox"/> Has own transportation <input type="checkbox"/> Able to access transportation <input type="checkbox"/> Limited access to transportation		

Highest Level of Education		Education Status	School Name:
Living Arrangement	<input type="checkbox"/> self (alone) <input type="checkbox"/> spouse/partner <input type="checkbox"/> relatives <input type="checkbox"/> non-relatives (friends, roommate) <input type="checkbox"/> other (rest home, shelter, motel...)		
Residence Status	<input type="checkbox"/> independent (no assistance, slight assistance) <input type="checkbox"/> assisted/supportive (daily/weekly worker/relative support) <input type="checkbox"/> supervised (24/7 staff support) <input type="checkbox"/> other (unknown, treatment, hospital...)		
Legal Status/Issues	<input type="checkbox"/> no issues <input type="checkbox"/> pending/awaiting <input type="checkbox"/> Other: _____ (probation, NCR, immigration...)		

Primary Psychiatric Diagnosis (or query)		Other Psychiatric Diagnoses (or query)	
Current Barriers to Recovery	<input type="checkbox"/> Housing <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Education	<input type="checkbox"/> Employment <input type="checkbox"/> Volunteering <input type="checkbox"/> Leisure/Recreation <input type="checkbox"/> Physical Health	<input type="checkbox"/> Relationships <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Harm Self/Other
Other Chronic Illnesses or Disabilities	<input type="checkbox"/> Substance Use/Addictions <input type="checkbox"/> Access to Health Services/ Social Services <input type="checkbox"/> Daily Living Skills <input type="checkbox"/> Other: _____		

APPLICANT'S COMMUNITY SUPPORTS

	1. Current	2. Referral	Service/Support	Name	Contact Number
Please list all supports	<input type="checkbox"/>	<input type="checkbox"/>	Family/Friends		
	<input type="checkbox"/>	<input type="checkbox"/>	Guardian/Trustee/ POA (Substitute Decision Maker)		
1. <u>currently</u> being accessed by the applicant	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Services (Case Management, ACTT, PACT)		
	<input type="checkbox"/>	<input type="checkbox"/>	Family Doctor		
	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatrist		
	<input type="checkbox"/>	<input type="checkbox"/>	Addictions Services (ie. ADAPT, AA...)		
2. the applicant is being <u>referred to</u>	<input type="checkbox"/>	<input type="checkbox"/>	Community Services (ie. CCAC, Links2Care...)		
	<input type="checkbox"/>	<input type="checkbox"/>	Counselling/Therapy		
	<input type="checkbox"/>	<input type="checkbox"/>	Crisis Services (ie. COAST)		
	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Services		
	<input type="checkbox"/>	<input type="checkbox"/>	Employment/Income Agency (ie. STRIDE, ODSP...)		
	<input type="checkbox"/>	<input type="checkbox"/>	Housing Agency		
	<input type="checkbox"/>	<input type="checkbox"/>	Other (lawyer, church, probation)		

REFERRAL CHECKLIST: *(Referrals cannot be processed until a completed referral form and signed or verbal consent are received. Incomplete referrals will be returned to the Referral Source)*

- The applicant is aware that a referral has been made to the CMHA-HRB Case Management Programs.
- The applicant is willing to be goal directed and is aware that participation in the Case Management Programs is voluntary.
- Any available admission/discharge summaries, clinical reports, assessments & hospital records have been included with this referral.
- A signed consent form has been enclosed.

Case Management Programs Referral Form completed via Telephone; Verbal consent obtained by applicant

Signature of Referral Source: _____ Date of Referral: _____

For Office Use Only

Date Referral Received		Initial Contact Date		Referral Worker	
Referral Outcome	<input type="checkbox"/> Pending Assessment <input type="checkbox"/> Closed	<input type="checkbox"/> Referral(s) Made	Details/Comments		

