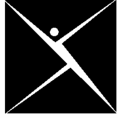

2 Kent Street West, 2nd Floor
Lindsay, Ontario
K9V 2Y1
Phone: (705) 328-2704
Fax: (705) 328-2456

Canadian Mental Health Association Kawartha Lakes Branch

Market Square Apartments Application

SECTION A: IDENTIFYING INFORMATION

First Name: ____________________

Last Name: ____________________

Middle Name: __________________

Address: ____________________________

____

Telephone: ____________________

Can We Leave Messages? Yes / No

Gender: Male / Female

Marital Status: _______________________

S.I.N: _________________________

Date of Birth: ________________________

Preferred Language: ____________

Religion: ____________________________

EMERGENCY CONTACT:

Name: _________________________

Relationship: _______________________

Telephone: _____________________

Address: ____________________________

____

SECTION B: REFERRAL INFORMATION

Name and Title of Referral Source: ____

Organization: ____

Address: ____

Telephone Number: __________________

Attached Consent to Disclose Information: Yes / No

Will Referring Agency continue to be involved? **Yes / No**

Comments: ____

____

____

If "no", who will provide follow-up?

Comments: ____

____

____

What Agencies and/or professionals are you currently involved with and what goals are you working and/or services received from each agency?

____

____

____

____

SECTION C: STATUS HISTORY

Who does the applicant currently live with? ______________________

Source of Income: ______________________________

Highest level of education completed: ______________________

Are they currently in school? ______________________

What is their legal status (if applicable): ______________________

Details of any of the above: ______________________

____

____

SECTION D: MEDICAL INFORMATION

Family Physician:__________________ **Telephone:**____________________

Other Physician: __________________ **Telephone:** ___________________

Psychiatrist:_______________________ **Telephone:**____________________

Health Card #:______________________ **Eye Color:** ___________________

Ethnicity: _________________________ **Height:** ______________________

Weight: ___________________________ **Build:** _______________________

Hair Color and Style: ____

Allergies: ____

Distinguishing Characteristics/Unusual Features (moles, tattoos, scars, etc):

____

Diagnosis(es):

Axis 1: ____

Axis 2: ____

Axis 3: ____

Axis 4: ____

G.A.F Score (if known): ____

Discussion of Symptoms Experienced:

____

____

____

____

Present Medications	Dosage	Duration Taken & Side Effects

Past Medications **Dosage** **When, Duration & Side Effects**

Are you able and willing to take medication prescribed? YES / NO

Do you need reminders to take your medication? YES / NO

Do you have a routine and/or way of remember to take your medication?

Describe a time in the past when you stopped taking your medication (when was this, why did you stop, and what happened?)

Predictors of Relapse (How do you know you are getting sick again? What happens, how do you feel when you know your illness is relapsing?

Successful Interventions. (What have others or yourself done in the past to help you cope and/or prevent a relapse?).

____

____

____

Previous Psychiatric Hospitalizations:

Admission Date	Discharge Date	Hospital Name	Reason(s) for Admission	Support Received

SECTION E: HOUSING INFORMATION

Current Type of Housing:

Family Residence **Alone** **Boarding Home** **Hospital**

Other: ___________________________________

Briefly list previous types of housing:

Types **What Liked & Disliked**

____

____

____

Briefly state why you want to live at Market Square; what are your goals for moving to Market Square?

____

____

____

____

____

____

____

SECTION F: RISK ASSESSMENT COMPLETED BY REFERRAL SOURCE

Office Use Only

SUICIDE:

History	Last 6 months	
☐	☐	Attempted suicide?
☐	☐	Experienced suicidal thoughts? (if yes, how often?)
☐	☐	Family history of suicide?
☐	☐	Feelings of hopelessness?
☐	☐	A plan to kill yourself?

Details:

Office Use Only

SELF-HARM:

History	Last 6 months	
☐	☐	Cut yourself?
☐	☐	Burned yourself?
☐	☐	Binged and/or purged?
☐	☐	Purposely stopped taking your medication?
☐	☐	Poor nutrition habits?
☐	☐	Stopped taking care of your own hygiene?
☐	☐	Hurt yourself in any other way?

Details:

Office Use Only

VIOLENCE:

History	Last 6 months	
☐	☐	A criminal record?
☐	☐	Physically attacked someone?
☐	☐	Threatened to harm someone?
☐	☐	Access or means to a weapon?
☐	☐	

History of destroying property?

☐ ☐ History of arson/careless smoking habits?

☐ ☐ Outbursts of anger?

☐ ☐ Thoughts of violence?

☐ ☐ A plan to hurt someone?

☐ ☐ Homicidal thoughts?

Details:

Office Use Only ☐

HOMELESSNESS:

History	Last 6 months	
☐	☐	Experienced homelessness?
☐	☐	Given a notice of eviction or forced to leave your housing?
☐	☐	Pay more than 50% of your income on housing costs?

Details:

Office Use Only ☐

ABUSE/TRAUMA:

History	Last 6 months	
☐	☐	Experienced emotional abuse?
☐	☐	Experienced physical abuse?
☐	☐	Experienced sexual abuse?
☐	☐	Been neglected?
☐	☐	Witnessed someone else being abuse?
☐	☐	Family history of abuse?
☐	☐	Been exposed to any other type of violence? (Ex. “rough neighborhood”)

Details:

Office Use Only

ADDICTIONS

History	Last 6 months	
☐	☐	Street drug dependence?
☐	☐	Alcohol dependence?
☐	☐	Prescription drug dependence?
☐	☐	Accessed treatment for substance abuse?
☐	☐	Problem with gambling?

Details:

Office Use Only

MENTAL HEALTH

History	Last 6 months	
☐	☐	Delusions?
☐	☐	Hallucinations?
☐	☐	Paranoia?
☐	☐	Mood swings?
☐	☐	Outbursts of anger?
☐	☐	Isolate?
☐	☐	Periods of anxiety and/or panic?
☐	☐	Periods of depression?
☐	☐	Periods of mania?
☐	☐	Difficulty with impulse control?
☐	☐	Experienced a significant loss?
☐	☐	Family history of mental illness?

Details:

SECTION G: ACTIVITIES OF DAILY LIVING SKILLS/SUPPORTS

Please describe your abilities and/or needs for support in the following areas:

1. **Cooking Skills:**
____
____

2. **Household Skills (e.g. cleaning, vacuuming, etc):**
____
____

3. **Budgeting (banking, rent, unpaid debts):**
____
____

4. **Hygiene routines:**
____
____

5. **Transportation (own vehicle, public transportation):**
____
____

6. **Family Contact & Supports:**
____
____

7. **Relationship skills (how well do you get along with others):**
____
____

8. **Do you have any mobility difficulties? (climbing stairs, lifting, walking, difficulty breathing, etc).**
____
____

9. **Any additional information:**
____
____

SECTION H: REFERRING SIGNATURES:

______________________________ ______________________

Applicant's Signature **Date**

______________________________ ______________________

Referral Source **Date**

SECTION I: OFFICE USE ONLY

______________________________ ______________________

Applicant's Signature **Date**

______________________________ ______________________

Case Manager **Date**

______________________________ ______________________

Team Leader Mental Health Services **Date**

Application Review Date: ______________________________

Move into Market Square: **YES / NO**

If yes, date: ____

Other Recommendations:

____

____

____

MARKET SQUARE APPLICATION INFORMATION SHEET

Please retain for your records

Market Square:

The purpose of Market Square Apartments is to provide safe, decent, permanent and affordable housing to people who have suffered with a mental illness, but who are capable of living independently in the community.

The apartment complex includes 6 one-bedroom apartments and a community room, which provides a centre for Public Education and Social Recreation.

Eligibility:

Individuals in the City of Kawartha Lakes, the County of Haliburton and the Township of Brock in the Region of Durham who are 18 to 65 years of age with a mental health issue can access this program. No referral is necessary. Applicants will be interviewed to determine their level of ability and appropriateness for the Market Square program.

Application Instructions:

Please complete this application in collaboration with the applicant. Please provide as much detail as possible as this will assist the Mental Health Services team in their assessment process. Once the application is completed, please fax it back to the Canadian Mental Health Association at **(705) 328-2456 Attention Intake Services**.

Follow-up Procedure:

Once the application is received by the Intake Worker, the applicant will be placed on the waitlist. When there is a vacancy, individuals on the waitlist will be interviewed to determine their eligibility.

If you have any questions or concerns about the application process, or would like to know more about Market Square, please do not hesitate to contact the Intake and Brief Services Workers at (705) 328-2704 ex. 224 or ex. 230. Information is also available online at www.cmhakawarthalakes.ca.

Thank you for considering Market Square.