Canadian Mental Health Association
Association canadienne pour la santé mentale
Simcoe County
GAMBLING, SUBSTANCE USE & MENTAL HEALTH SERVICES

ACCREDITED WITH COMMENDATION
ACCREDITATION AGRÉMENT CANADA

Canadian Mental Health Association

Simcoe County Branch

Community Homes for Opportunity (CHO) Referral Form

Form Date*(required)

Referral Source (Name/Agency)

Referral Contact Email Address*(required)

Referral Contact Phone Number

Reason for the referral

Preference for Location*(required) ***Select all areas that apply.***

Midland/Penetanguishene Lafontaine Collingwood

Applicant

First Name

Last Name

Alias (also known as)

Health Card Number

Health Number Version Code

Address

Gender Identity

Date of Birth **Age** **Email**

Home Number

Alternate Number

Voice Mail?
Yes No

Can we Leave a message?*(required)
Yes No

How can we contact you?
Phone Email

When is it best to contact you?
8:30 am – 1:00 pm 1:00 pm – 4:30 pm 4:30 pm – 6:00 pm (Wednesdays only)
Anytime

Substitute Decision Maker (SDM) Name (if applicable)

Please note, proof of SDM status may be requested at any time during the intake or assessment process.

Is Client aware of the referral being made?*(required)
Yes No Unknown

Is there a mental health diagnosis?*(required)
Yes No

Does Client give permission for CMHA contact the referral source?*(required)
Yes No

Income Source*(required)

ODSP Ontario Works CPP Employment No Income
Other Family Support
CPP/OAS or Private Pension

Select all that apply.
Does Client have any of the following conditions in place?*(required)

Community Treatment Order Ontario Review Board Order
Parole Conditions Bail Conditions
Unknown None

Copies of all documentation will be required as part of the eligibility assessment process.

Is client able to move independently in the community?*(required)
Independent in community
Requires support with some activities in the community
Requires support with all activities in the community
Requires escort and/or supervision in the community
Unknown

Community Support Identified along with contact information

(i.e. ACTT, PI, Family, PGT, ODSP, GP, CDP)

Housing History: Provide details of living situation over the past 5 years through present day *(required)

Activities of Daily Living
Indicate level of support or skill development client requires in the following areas:

	High Support	Medium Support	Low Support	Independent	Unknown
Incontinence*(required)	☐	☐	☐	☐	☐
Showering*(required)	☐	☐	☐	☐	☐
Hygiene*(required)	☐	☐	☐	☐	☐
Grooming*(required)	☐	☐	☐	☐	☐
Meal Preparation*(required)	☐	☐	☐	☐	☐
Shopping*(required)	☐	☐	☐	☐	☐
Budgeting and Finance Management*(required)	☐	☐	☐	☐	☐
Medication Management*(required)	☐	☐	☐	☐	☐
Mobility*(required)	☐	☐	☐	☐	☐

Comments on level of support needed:

Physical Health (Concerns)

Mental Health (Concerns)

Substance Use (current and past)

Legal Concerns/Involvement (current and past)

Community Involvement

Goals

Spirituality

Housing Needs/Preferences

Other information we gather prior to scheduling tours include:

Social Work Assessment

OT Assessment (if available)

Nursing Assessment (if available)

Risk Assessment (if available)

Crisis Plan (if available)

Current living situation (i.e. in a lease and needing to give 60 days' notice, etc.)

Information needed prior to move in:

List of current medications and pharmacy information if not previously noted

Emergency Contact Information

3 months' bank statements

Notice of Assessment from last year's income tax

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Copies of ID

Transition Plan and Upcoming Appointment Schedule

Send completed forms to chointake@cmhastarttalking.ca