

**Access 1  
Common Application Form**

---

**WELCOME!**

---

Access 1 is a partnership between several individual support service providers in North York and Scarborough. In order to apply for the services and organizations listed on this form, **you need to live in North York or Scarborough**. The partners listed below will all accept this form as an **initial** application for individual support services.

You may apply to up to **three** organizations listed on this form. Please note that your initial application will be considered by all the organizations that you have applied to, one at a time, but you may only stay on **one** waitlist for service. If applying to more than one organization, please indicate your first, second and third choice next to the name of the organizations you are applying to for service. Once you and the organization you have chosen have agreed that you are eligible for their waitlist, the other organizations you have chosen will be informed of this and your name will be removed from being considered for service with them.

Individual Support Services include **mental health case management** and **assertive community treatment team** services. You **may** be eligible to apply if you are:

- 16 years of age or older
- Have mental health problems that are seriously affecting your life
- Live in North York or Scarborough

**Please call individual agencies for information on their eligibility requirements and program details.**

Please answer as many questions as you can. Please PRINT all answers in ink. Should you have any questions or require assistance with filling in this form, please call the organization whose services you are interested in and a staff person will be happy to help you.

Please read the Declaration and Consent section on page 8 and sign the application form. **The confidentiality of the information you provide will be respected in adherence with the Personal Health Information Privacy Act (PHIPA).**

Mail or fax the completed application form to the address and fax number below. You may also apply on-line at [www.access1.ca](http://www.access1.ca).

**Applications may be mailed to: Access 1  
132 Railside Road, Unit 2,  
Toronto, Ontario M3A 1A3**

**Toll-Free #: 1-888-640-1934**

**Fax: 416-499-9716**

**Please Note that all applications will be processed by the Access 1 office.**

**PART I**

Date of Application: \_\_\_\_\_

- **Intensive Case Management** (People with serious mental illness are provided one on one case management support to live in the community and be linked to appropriate services by their case manager)
- **Crisis Management Support** (Crisis support and planning services for people living with mental illness.)
- **Assertive Community Treatment Teams (ACTT)** (Multi-disciplinary teams provide treatment, rehabilitation and support to people with severe mental illness in their recovery. Specific eligibility criteria apply)

**Programs Offered and Boundaries**

Please check off the box for the agency/ies whose services you wish to apply for. *Please indicate which is your first, second and third choice agencies if you are applying for more than one agency.*

**Across Boundaries** (People from ethnoracial communities): GTA**Tel: 416-787-3007****Fax (Access 1 Office): 416-499-9716** Case Management**Bayview Community Services** (Professional referrals only):

Eglinton Avenue – Steeles Avenue &amp; Bathurst Street – Kennedy Ave.

**Tel: 416-495-7778 ext. 22****Fax (Access 1 Office): 416-499-9716** Case Management**CMHA (Toronto East):** Scarborough**Tel: 416-289-6285 ext. 243****Fax (Access 1 Office): 416-499-9716** Case Management East (Including Rehabilitation Action Program) ACTT**CMHA (Toronto West)****Tel: 416-789-6880****Fax (Access 1 Office): 416-499-9716** Case Management (West): Steeles Ave.– Lake Ontario & Yonge St. to Humber River ACTT (West): Steeles Ave. – Eglinton Ave. & Allan Rd. – Humber River**COTA Health:** GTA**Tel: 416-785-9230****Fax (Access 1 Office): 416-499-9716** Regular Case management Hostel Outreach Program Case Management (Dual Diagnosis) Case management (Geriatric Mental Health)**CRCT:** Downtown, Scarborough and North York**Tel: 416-482-4103 ext. 316****Fax (Access 1 Office): 416-499-9716** Case management (individual – Scarborough and North York as well as Central/Downtown) Case Management (Family) Case Management (Tamil and Somali) Case Management (Early Intervention)

**Griffin Centre & Community Support Network:** City of Toronto

**Tel: 416-222-3563**

**Fax: (Access 1 Office) 416-499-9716**

- Short-term case management (Dual Diagnosis)  
 Short-term case management (transitional age youth)

**North York General Hospital:** Victoria Park Ave.- Dufferin St.& Highway 7– Old Southern North York Boundary

**Tel: 416-632-8708**

**Fax (Access 1 Office): 416-499-9716**

- ACTT services

**Saint Elizabeth Health Care:** Former cities of North York & Etobicoke

**Tel: 416-498-0043**

**Fax (Access 1 Office): 416-499-9716**

- Crisis management support

**Scarborough Hospital:** Victoria Park Ave.–Port Union Rd & Kingston Rd. – Steeles Ave.

- Intensive Case Management

**Tel: 416-724-7919**

**Fax: (Access 1 Office) 416-499-9716**

- ACTT services

**Tel: 416-289-6285 ext 243**

**Fax: (Access 1 Office) 416-499-9716**

**Sunnybrook Hospital:** Sheppard Ave. – St. Clair Ave. & Bathurst St.– DVP **Tel: 416-480-4611**

**Fax (Access 1 Office): 416-499-9716**

- ACTT Services (SunPACT)

**Toronto North Support Services:**

Eglinton Ave. – Steeles Ave. & Victoria Park Ave.- Humber River.

**Tel: 416-499-5969**

**Fax (Access 1 Office): 416-499-9716**

- Case management (Community Support Program)  
 Case management (Passages French language program)  
 Case management (Mental Health Street Outreach)

**Where does the applicant live?**

North York

Scarborough

Other \_\_\_\_\_

**PART II****A/ HOW CAN WE CONTACT YOU?*****Applicant:***

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Apt. No: \_\_\_\_\_ Entry code: \_\_\_\_\_ Telephone No.: \_\_\_\_\_ Extension: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Former municipality:  North York  Scarborough  Other Major intersection: \_\_\_\_\_

If you do not have a phone or are otherwise difficult to reach, is there someone with whom you are in regular contact that we can call in order to reach you?

Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_ Extension: \_\_\_\_\_

Relationship or organization: \_\_\_\_\_

Can a message be left at the phone number provided?  Yes  No**B/ REFERRAL SOURCE INFORMATION (Please complete if not a self-referral):**

Referrer's name: \_\_\_\_\_ Agency: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt./Suite No.: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Do You Intend To Remain Involved With The Applicant If He/She Secures Case Management Services?  Yes  No

If Yes, Please Describe The Level of Involvement That You Intend To Maintain:

\_\_\_\_\_  
\_\_\_\_\_

## C/ INFORMATION TO HELP US DIRECT YOUR APPLICATION

**Date of Birth:** (mm/dd/yy) \_\_\_\_\_

**Gender:**  Male  Female  Transgender  Transsexual  Other

**Do you have an Ontario Health Card:**  Yes  No  Don't know

**Do you speak English:**  Yes  No  Some

**What is your first language(s):**  English  French  Other \_\_\_\_\_

**What is your preferred language:**  English  French  Other \_\_\_\_\_

*Some individual support service organizations offer a range of supports and services to people from specific ethno/racial communities who are experiencing mental illness. If these services are of interest to you, please check the community/communities that applies to you in order to match you with the most appropriate service. Please note that this question is optional.*

- |                                      |                                     |  |   |
|--------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Aboriginal  | <input type="checkbox"/> Caribbean  | <input type="checkbox"/> African continent | <input type="checkbox"/> South East Asian     |
| <input type="checkbox"/> South Asian | <input type="checkbox"/> West Asian | <input type="checkbox"/> Middle Eastern    | <input type="checkbox"/> Latin American       |
| <input type="checkbox"/> Japanese    | <input type="checkbox"/> Korean     | <input type="checkbox"/> Chinese           | <input type="checkbox"/> Pacific Islanders    |
| <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Cambodian  | <input type="checkbox"/> Unknown           | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Other _____ |                                     |  |   |

*Some individual support services organizations offer a range of services in addition to case management and ACTT services that you **might** be eligible for. If you are interested in any of the services listed below, please check the appropriate box. This form is NOT an application for these services, but will help the agencies match you with the most appropriate service.*

- Housing Programs  Employment Programs  Social Support Programs  Peer Support Programs
- Early Intervention Programs  Transitional Youth Programs  Court Support Programs
- Educational and Support Group Programs

**Who do you presently live with? Please check all boxes that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Self                     | <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Spouse/partner & others |
| <input type="checkbox"/> Parents                  | <input type="checkbox"/> Relatives      | <input type="checkbox"/> Non-Relatives           |
| <input type="checkbox"/> Children (Age/Sex) _____ |   |  |

**Are you currently homeless or at risk of becoming homeless?**

- Yes  No  Somewhat

**What type of housing do you presently live in?**

- |  |   |
|--|---|
| <input type="checkbox"/> Approved Homes & Homes for Special Care | <input type="checkbox"/> Private House/Apt.- Client Owned /Market                                 |
| <input type="checkbox"/> Correctional/Probational Facility       | <input type="checkbox"/> Rent   |
| <input type="checkbox"/> Domicillary Hospital                    | <input type="checkbox"/> Private House/Apt.- Other/Subsidized                                     |
| <input type="checkbox"/> General Hospital                        | <input type="checkbox"/> Retirement Home/Senior's Residence                                       |
| <input type="checkbox"/> Psychiatric Hospital                    | <input type="checkbox"/> Rooming/Boarding House   |
| <input type="checkbox"/> Other Specialty Hospital                | <input type="checkbox"/> Supportive Housing – Congregate Living                                   |
| <input type="checkbox"/> No fixed address                        | <input type="checkbox"/> Supportive Housing – Assisted Living<br>(RTF 24 hr Home and Group Homes) |
| <input type="checkbox"/> Hostel/Shelter                          | <input type="checkbox"/> Private Non-Profit Housing   |
| <input type="checkbox"/> Long-Term Care Facility/Nursing Home    | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Municipal Non-Profit Housing            |   |

**What is your primary source of income?**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> ODSP        | <input type="checkbox"/> Social Assistance (e.g., Ontario Works) |
| <input type="checkbox"/> Employment  | <input type="checkbox"/> Employment Insurance                    |
| <input type="checkbox"/> Pension     | <input type="checkbox"/> Disability Assistance                   |
| <input type="checkbox"/> Family      | <input type="checkbox"/> No Source of Income                     |
| <input type="checkbox"/> Other _____ |  |

**Are you currently involved with the criminal justice system? (Please note, this will not affect your ability to receive service. It is to help us better direct your application)**  Yes  No  Do Not know

If yes, please indicate dates, types of involvement and outcome:

\_\_\_\_\_

Are you currently on a CTO order?  Yes  No

**D/ HEALTH INFORMATION**

**Is this your first experience with mental illness?**  Yes  No  Unknown

**How long have you been experiencing mental health difficulties (i.e., length of time)?** \_\_\_\_\_

**Have you been diagnosed with a mental illness?**  Yes  No  Unknown

**If yes, what was the diagnosis(es) ?** \_\_\_\_\_

**Have you ever gone to a Hospital Emergency Room due to mental health difficulties?**

Yes  No  Unknown

If Yes, how many times have you gone to an Emergency Room in the past two years? \_\_\_\_\_

**Have you been hospitalized due to mental health challenges in the last two years?**

Yes  No  Unknown

If Yes, please provide an estimate of the total number of days that you have spent in Hospital, due to mental health difficulties, within the past two years:

Estimated number of days: \_\_\_\_\_

**Are you in hospital now due to mental health issues?**  Yes  No

**Have you ever had an episode of psychosis?**  Yes  No  Unknown

**Do you have a psychiatrist?**  Yes  No

If Yes, please provide his/her contact Information:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Do you have a physician (e.g., GP, family doctor, walk-in clinic doctor)?**  Yes  No

If Yes, please provide his/her contact Information:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Do you have any other health conditions, problems (including allergies) or disabilities?  Yes  No  Unknown

If yes, please describe:

---



---



---



---

## E/ APPLICANT'S SUPPORT NEEDS

**Applicant is Requesting Support with:**

- |  |   |
|--|---|
| <input type="checkbox"/> Managing specific symptoms of serious mental health illness | <input type="checkbox"/> Developing daily living skills     |
| <input type="checkbox"/> Finances  | <input type="checkbox"/> Legal Issues                       |
| <input type="checkbox"/> Housing Needs   | <input type="checkbox"/> Relationships                      |
| <input type="checkbox"/> Educational Opportunities                                   | <input type="checkbox"/> Occupational/Employment/Vocational |
| <input type="checkbox"/> Substance Abuse/Addictions Issues                           |   |

**Applicant Comments Regarding Support Needs:**

Please briefly describe the reason(s) for your application. In which areas are you looking for support (e.g., recovery goals, self-care, housing/household care, finances, daily activities/education/employment, relationships, social activities, other)?

---



---



---



---

**Referral Source Comments Regarding Applicant's Support Needs:**

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support?

---

---

---

---

***We ask the following questions to determine if there are any safety or risk issues of which we should be aware. Answering any of the questions below will not exclude you from service. We know these are sensitive questions and we appreciate you answering them. If you have any recent (i.e., past three years) history of the following, please comment (e.g., when, how many incidents, how severe, outcome):***

Self-harm or suicide threats or attempts: \_\_\_\_\_

---

Substance use or treatment: \_\_\_\_\_

---

Aggression or violence (verbal, physical, sexual): \_\_\_\_\_

---

Destruction of property (including fire-setting): \_\_\_\_\_

---

At risk of becoming homeless or currently homeless: \_\_\_\_\_

---

**D/ EXISTING SUPPORTS**

Are you currently working with any other service providers?  Yes  No  Don't know

If yes, please provide the following information on each service provider with whom you are working:

Agency	Name/Contact Person	Service(s) Received	Telephone Number

Please describe the informal supports (e.g., family, friends, faith community, cultural groups/community, other community supports) in your life and how satisfied you are with each of these supports.

---



---



---



---



---

## YOUR DECLARATION AND CONSENT

---

This section outlines your agreement with the organizations you requested on page 1. We **promise that the confidentiality of the information you have provided will be respected in accordance with all applicable legislation.** Please **feel free to call any of the organizations you requested for** more information on how your confidentiality will be preserved. By checking the boxes below and signing this application form, you agree to what is set out in the following statements. Please read it carefully before signing.

### **APPLICANT'S DECLARATION & CONSENT**

I have done my best to ensure that the information provided in this application is correct.  Yes  No

I would prefer both my referrer and myself to be contacted for the initial assessment.  Yes  No

I understand that in order to determine my eligibility for individual support services and to identify programs that could best meet my needs, the intake staff:

\* Will contact me for further information and to discuss and update me regarding my application.  Yes  No  
I give my permission for this.

\* May contact and share information with the Referrer (if any) who signs the Referrer's Statement below.  Yes  No  
I give my permission for this.

\* Contact and share information with the service providers listed on pages 1 and 4 of this application form  Yes  No  
(e.g., psychiatrist, physician, other service providers), except for \_\_\_\_\_ (if any).  
I give my permission for this.

I understand that this application will be processed by the Access 1 office. I give my permission for this.  Yes  No

I understand that if I am eligible for individual support services, this application will be sent to those who are providing the service. I give my permission for this.  Yes  No

I understand that once I start receiving service from one organization, the other organizations chosen by me will be informed of this. I give my permission for this.  Yes  No

**Applicant's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you have chosen not to consent to any of the above statements, please explain:

---



---



---

**REFERRER'S STATEMENT**

If another person is referring the applicant, that person (the referrer) must complete this section of the application. By signing this application form, the referrer agrees to what is set out in the statement below. Please read it carefully before signing.

***Referrer's statement***

To the best of my knowledge, the information contained in this application is correct.

I have discussed this application with the applicant, explained the role of ***[Name of organization]*** and application process, and whenever possible, have completed this application together with the applicant.

I understand that ***[The name of the organization]*** will send this application with identifying information only to those agencies to which the applicant has agreed.

**Referrer's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_