COMMUNITY MENTAL HEALTH PROGRAM APPLICATION

A. DATE OF APPLICATION: ___/___/___ (DAY/MONTH/YEAR)

Is the applicant aware you are making this application/referral? ☐ Yes ☐ No **If no, please explain why.**

B. APPLICANT INFORMATION

Last name:	**First name:**	**Initial:**	**Male** ☐	**Female** ☐
Address	**Postal Code**	**Phone number:**		
Date of Birth (dd/mm/yy)	**MHSC #**	**PHIN #**	☐ **Aboriginal Status Treaty #** _________	

Relationship Status	☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Employment Status	☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Student ☐ Homemaker ☐ Retired
Source of Income	☐ Employment Income ☐ Employment & Income Assistance ☐ Disability (private) ☐ Pension ☐ Other: ___________________________
Financial Management	☐ Self ☐ Power of attorney ☐ Order of Committeeship ☐ Other: ________________________

C. REFERRAL SOURCE (Self-Referrals Go To "D.")

Name of Referral Source:	**Organization:**	**Phone:** **Fax:**

Referral Source

☐ Family Member ☐ Therapist/counselor ☐ Private physician ☐ Private Psychiatrist
☐ Concordia Hospital ☐ Grace Hospital ☐ Health Sciences Centre ☐ Seven Oaks Hospital
☐ St. Boniface Hospital ☐ Victoria Hospital ☐ Misericordia Urgent Care ☐ WPG Crisis Services
☐ Addictions Agency ☐ Housing Agency ☐ Vocational Program ☐ Self-Help Group
☐ Selkirk/Eden Mental Health Centres ☐ Public Trustee's Office ☐ Employment & Income Assistance
☐ Children & Adolescent Program ☐ Community Program
☐ Other government program:____________________ ☐ WRHA Program:______________________________
☐ Other: ____

D. PERSONAL INFORMATION CONTACTS: IN ORDER TO PROVIDE THE BEST SERVICE POSSIBLE, IT MAY BE NECESSARY FOR US TO CONTACT ONE OR MORE OF THE FOLLOWING PERSONS.

Next of Kin/Contact Person:	**Other Contact Person:**	**Other Agency/Agencies Involved:**
Name: Relationship to client: Address: Home Phone: Work Phone:	Name: Relationship to client: Address: Home Phone: Work Phone:	Names: Address: Phone: Fax
Family Physician: Name: Address: Phone: Fax:	**Psychiatrist:** Name: Address: Phone: Fax:	**Physician (Specialist/Other):** Name: Address: Phone: Fax:

1. Previous Involvement	**Previous involvement in a Winnipeg Community Mental Health Program?** ☐ Yes ☐ No ☐ Do Not Know **If yes, which program?** ☐ Community Mental Health Program (CMHW) ☐ Intensive case Management (ICM) ☐ Cross-Cultural ☐ Program for Assertive Community Treatment (PACT) ☐ Do not know
2. Referral Request	**Reason for requesting community mental health services?** **Check all that apply. If there is more than one, please rank the reasons in order of importance (1 to 3).** ☐ Treatment (assistance in managing illness including symptoms and medication). ____ ☐ Rehabilitation (assistance in reaching personal goals at work, school, home or social life). ____ ☐ Support (assistance in solving daily problems and acquiring support and assistance in the community). ____
3. Current Difficulties	**b) In what areas of life are difficulties being experienced?** ☐ Managing illness and symptoms ☐ Managing stress and emotions ☐ Budgeting and other financial matters ☐ School or employment ☐ Other (specify)________________________ ☐ Managing medications ☐ Daily living tasks like shopping or making meals ☐ Housing ☐ Family or social relationships ☐ Leisure or recreation activities
4. Diagnosis	**Mental health (psychiatric) diagnosis?** ☐ Yes ☐ No ☐ Do Not Know **If yes, what is the diagnosis?** Diagnosis One:__________________________________ Diagnosis Two:__________________________________
5. Hospitalization	**Prior hospitalization for mental health reasons?** ☐ Yes ☐ No ☐ Do Not Know **If yes, about how much time in the hospital in the past two years?** ☐ No admissions in past year ☐ Less than 3 months ☐ Between 3 and 6 months ☐ More than 6 months ☐ More than 1 year
6. Signs and Symptoms	**Difficulties with mental health in past month (for example, feeling depressed or anxious)?** ☐ Yes ☐ No ☐ Do Not Know **b) If yes, are these difficulties more or less than previous months?** ☐ More ☐ Less ☐ About the same ☐ Do not know **c) What are the difficulties?** ☐ Feeling sad or depressed ☐ Feeling hopeless or worthless ☐ Becoming confused or disoriented ☐ Feeling nervous, tense or anxious ☐ Frequent mood swings ☐ Easily agitated or angered ☐ Difficulties eating or unusual eating habits ☐ Other:______________________________ ☐ Difficulties sleeping or change in sleep habits ☐ Trouble understanding, concentrating or remembering ☐ Hearing voices or seeing things ☐ Having unusual thoughts or ideas ☐ Feeling that others are watching or talking about him/her/me ☐ Feeling as if others might somehow harm her/him/me

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<tr><td>7.
Physical Health</td><td>Physical disability or health problems? ☐ Yes ☐ No ☐ Do not know
If yes, please specify: ____________________
____
____
____
a) Is this a new, recent or long-term problem?
☐ New (within past month) ☐ Recent (within past 2 to 6 months) ☐ Long-term (6 plus months)
b) Physical difficulty in carrying out daily living routines because of this condition?
☐ Yes ☐ No ☐ Do not know</td></tr>
<tr><td>8.
Loss or Change</td><td>Important personal loss or change in recent past? ☐ Yes ☐ No ☐ Do not know
If yes,
☐ Loss of a close person through death, divorce, or separation
☐ Changed where he/she lives
☐ Failed or dropped out of school or training program
☐ Loss of a job or money problems
☐ Health problems because of an illness or accident
☐ Other: Specify________________</td></tr>
<tr><td>9.
Suicidality</td><td>Risk of harming self (including suicide)? ☐ Yes ☐ No ☐ Do not know
If yes, please indicate which of the following apply.
☐ Has a history of harming self (e.g., cutting or burning self)
☐ Presently having thoughts of wanting to harm self (but not to end life)
☐ Presently has plan to harm self
☐ Presently having thoughts of wanting to end life
☐ Presently has plan to end life
☐ Has a history of suicide attempt(s)
Please describe current self-harm or suicide risks:
____
____
____________________</td></tr>
<tr><td>10.
Risk to Self from Others</td><td>Fear of being hurt by another person? ☐ Yes ☐ No ☐ Do not know
If yes, explain: ____________________
____
b) Presently in a safe place? ☐ Yes ☐ No ☐ Do not know</td></tr>
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11. Risk to Others	**Threatened or hurt another person when upset or angry?** ☐ Yes ☐ No ☐ Do not know **If yes, was this an isolated incident?** ☐ Yes ☐ No ☐ Do not know **Risk to others in what way?**____ ____ ____
12. Substance Use / Gambling	**Current or past concerns with any of the following (please check all that apply):** ☐ Alcohol ☐ Drugs ☐ Gambling ☐ Cigarettes ☐ Other: __________________ ☐ None ☐ Do not know
13. Housing	**Presently without housing or at risk of losing his or her housing?** ☐ Yes ☐ No ☐ Do not know **If yes, please explain:** ____ ____ **b) Has a safe place to go if housing is lost?** ☐ Yes ☐ No ☐ Do not know **c) Are supports needed to find and keep housing?** ☐ Yes ☐ No ☐ Do not know
14. Crisis Services Use	**In the past month, used an in-person crisis service like the Mobile Crisis Unit, the Crisis Stabilization Unit, or a hospital emergency department (not a telephone crisis line) to help with emotional or mental health difficulties?** ☐ Yes ☐ No ☐ Do not know
15. Social Supports	**Has family and friends who are emotionally supportive and available to help with daily needs and problems.** ☐ Yes ☐ No ☐ Do not know
16. Cross-Cultural	**Difficulty using health or social services because of language or culture?** ☐ Yes ☐ No ☐ Do not know **b) Language Preference:** ☐ English ☐ French ☐ Other: ____________________ Explain difficulties if experienced: ______________________________________ ____ ____ ____ ____ ____

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<tr><td>17.
Multi-System Involvement</td><td>

Other professional supports like a doctor or counsellor available to help with mental health or emotional needs? ☐ Yes ☐ No ☐ Do not know

b) Health and social supports currently used? ☐ Yes ☐ No ☐ Do not know

If yes, please specify:

Health Services
☐ Home care ☐ Public Health ☐ Primary Care ☐ Family Physician ☐ Psychiatrist
☐ Therapist ☐ Mental Health ☐ Self-Help ☐ Other: ______________________

Family Services
☐ Employment & Income Assistance ☐ Vocational Rehabilitation Services ☐ Community Living
☐ Children's Special Services ☐ Provincial Special Needs Unit ☐ Other: __________________

Other Services
☐ Education and Training ☐ Corrections and Justice ☐ Immigration ☐ Other: ___________

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<tr><td>18.
Program Preference</td><td>

The WRHA Community Mental Health Service is comprised of four different programs. Please identify the program that seems to best suit the applicant.

☐ The **Community Mental Health Program (CMHW)** provides assistance for persons with a mental health diagnosis who require support to develop skills and obtain resources to live successfully in the community
☐ The **Cross-Cultural Mental Health Specialist** provides assistance to persons with mental health difficulties who may be refugees or recent immigrants to Canada and experience language or cultural barriers that limit access or use of other services.
☐ The **Intensive Case Management Program (ICM)** provides assistance to persons with a mental health diagnosis who want to pursue major life goals such as choosing, getting or keeping their home, place of work or education program.
☐ The **Program for Assertive Community Treatment (PACT)** provides treatment along with assistance in developing Skills and supports for persons with a mental health diagnosis who face difficulties in meeting basic daily needs.

☐ **Do Not Know**

Please provide a written explanation for this preference.

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Signature of Applicant: ______________________________

Signature of Referral Source: ______________________________

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<tr><td colspan="2">QUESTIONS ABOUT THIS APPLICATION CAN BE ANSWERED BY CONTACTING WHRA CENTRAL INTAKE AT 940-2655.</td></tr>
<tr><td colspan="2">COMPLETED APPLICATIONS TO BE MAILED OR FAXED TO: WRHA COMMUNITY MENTAL HEALTH ACCESS COORDINATOR, 763 PORTAGE AVENUE, WINNIPEG, MANITOBA , R3G 0N2. FAX NUMBER: 940-2644.</td></tr>
<tr><td colspan="2">INTERNAL USE ONLY:
NAME OF WRHA WORKER COMPLETING APPLICATION: ____________________ PHONE: ______________</td></tr>
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