Canadian Mental Health Association Peel Dufferin
Mental health for all

Association canadienne pour la santé mentale Peel Dufferin
La santé mentale pour tous

McEvenue Home Works

Supplemental Application Form

REGISTRANTS INFORMATION		CRMS # (internal applicants):	
Name:		**Birth Date:**	

All applicants must complete this form in full and submit along with the following documents:

☐ Central West LHIN Registration Form Mental Health and Addiction Services *(not required for applications internal to CMHA PD)*

☐ Proof of income for all sources indicated

☐ Most recent bank statement, including the last 30 days

Additional supporting documentation may need to be provided upon request

Reason for application:

☐ Assist with rent, mortgage or utilities payments (up to a maximum of $2,000): Select from Dropdown

- ☐ Rent/Mortgage: Provide rental agreement, lease or letter from landlord confirming address, amount of monthly rent & date of occupancy OR provide mortgage statement
- ☐ Arrears/Bridge Funds: Provide all the above documentation & proof of arrears

☐ Funds to purchase, replace or repair items to maintain status as a tenant in good standing and maintain a healthy and safe living environment (up to a maximum of $1,000)

- ☐ Repairs: Provide two or more quotes for cost of repairs
- ☐ Furnishings: Provide two or more quotes for cost of furnishings
- ☐ Bedbugs: Provide two or more quotes for cost of repairs & verification that residence has been sprayed for treatment of bedbugs

☐ Other (up to a maximum of $1,000)
(Please Specify):

About McEvenue Home Works

McEvenue Homeworks can provide funds to assist with maintaining safe, appropriate, and sustainable housing in our service area, which includes Peel, Dufferin, North Etobicoke and West Woodbridge. Payment will be made directly to the landlord or organization providing the housing or service requested, and cheques or payment transfers may identify CMHA Peel Dufferin as the payor. CMHA Peel Dufferin can provide support to help you maintain good standing with the landord or service provider during the course of the application process

Amount being requested:	$	Payment due by:	
Amount payable to:			
Vendor address:			
Vendor City:		Vendor Postal Code:	
Payment type:	Select from dropdown		

If the amount required is greater than the maximum funds you are applying for ($1,000 or $2,000 as indicated above), please describe how the remainder of the cost will be paid.

Please indicate current monthly income from all sources that apply:

ODSP	$	E.I.	$	Spousal/child support	$	Income from other household members	$
Ontario Works	$	Pensions	$	Savings	$		$
CPP or CPP-D	$	Long-term disability	$	Child tax benefits	$		
Employment	$	RRSPs	$	Other (specify)	$		

What steps have been taken to address your housing issue?

Please briefly describe how your current housing concerns have impacted your mental health and/or substance use:

Information about other household members:

Name:		Relationship:		Is this person a dependent?	Select:
Name:		Relationship:		Is this person a dependent?	Select:
Name:		Relationship:		Is this person a dependent?	Select:
Name:		Relationship:		Is this person a dependent?	Select:

How did you hear about McEvenue Home Works?

If approved, may we contact you to understand how McEvenue Home Works has been helpful to you? ☐ Yes ☐ No

******* OFFICE USE ONLY ******

Funds approved	Select:	Amount approved	$	Date	
Program Manager/Director Signature				Date	

CC: Corporate Services

Central West LHIN Registration Form
Mental Health and Addictions Services

Canadian Mental Health Association Peel Dufferin *Mental health for all*

Association canadienne pour la santé mentale Peel Dufferin *La santé mentale pour tous*

Ontario Central West Local Health Integration Network Réseau local d'intégration des services de santé du Centre-Ouest

Inquiries: Central Intake (905) 451-2123

Website: cmhapeeldufferin.ca

Acceptance of registration requires legible answers for all fields on the two pages, including indicating the choice not to answer.

REGISTRANT'S INFORMATION		Health Card #:	
Last Name:		Gender:	Female / Trans
First Name:			Intersex / Do not Know
Birth Date:	Day / Month / Yr		Male / Prefer not to answer
Street Address:			Other:
City/Town, Prov.:		Postal Code:	
Email:		Internet access?	No / Yes
Home:	Cell:		Yes, you may text

What details can be left in a message? *(after the second failed attempt to contact you, your alternate contact will be phoned/emailed)*	Caller's Name Reason for call	Agency Name Follow up Required	Phone number Appointment Info
Barrier to Communication:	Limited/no English / Cognitive	Hearing / Sight	Other:
If not most comfortable speaking in English, is an interpreter needed?	No	Yes	Do not know
Is this referral from an Emergency Department Visit for Addictions or Mental Health?	No	Yes, please specify the hospital:	
Is this referral from a Mental Health Inpatient unit?	No	Yes, specify hospital:	

Alternate Contact:		Relationship:	
Phone:	Cell:	Email:	

Reason for Referral: - concerns - diagnosis - situation - symptoms - risk to self/others	
Medications (list or attach all current medications):	
Supportive Housing requested? No / Yes	Vocational Supports requested? No / Yes

Referral Source Name:		Billing #:	
Professional Designation:		Email:	
Agency Name and Office Mailing Address: *(affix sticker or stamp)*		Phone:	
		Fax:	

Before faxing clinical information, please ensure fax number (**905-456-7492**) is automatically programmed into your equipment.

February 2017

We Ask Because We Care

Mental Health and Addictions providers in Brampton, Bramalea, Bolton/Caledon, Dufferin County, North Etobicoke, Malton, and west Woodbridge (the Central West LHIN) are collecting social information from individuals seeking service to find out who we serve and what are the unique needs amongst these individuals. We will also use this information to understand people's experiences and outcomes.

1. Do I have to answer all the questions? No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

2. Who will see this information? This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other inidividuals and no one will be able to identify any of the individuals seeking service.

What language would you feel most comfortable speaking in with your health care provider? Choose ONE.

☐ Amharic	☐ English	☐ Korean	☐ Somali	☐ Urdu
☐ Arabic	☐ Farsi	☐ Nepali	☐ Spanish	☐ Vietnamese
☐ ASL	☐ French	☐ Polish	☐ Tagalog	☐ Other (specify):
☐ Bengali	☐ Greek	☐ Portuguese	☐ Tamil	
☐ Chinese (Cantonese)	☐ Hindi	☐ Punjabi	☐ Tigrinya	☐ Do not know
☐ Chinese (Mandarin)	☐ Hungarian	☐ Russian	☐ Turkish	☐ Prefer not to answer
☐ Czech	☐ Italian	☐ Serbian	☐ Twi	
☐ Dari	☐ Karen	☐ Slovak	☐ Ukrainian	

Were you born in Canada? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

If not born in Canada, what year did you arrive? ☐ Please check if the year provided is a guess/estimate

Which of the following best describes your racial or ethnic group? Choose ONE.

☐ Asian - East (e.g. Chinese, Japanese, Korean)	☐ Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ Asian - South (e.g. Indian, Pakistani, Sri Lankan)	☐ Metis
☐ Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ Black - African (e.g. Ghanaian, Kenyan, Somali)	☐ White - European (e.g. English, Italian, Portuguese, Russian)
☐ Black - Caribbean (e.g. Barbadian, Jamaican)	☐ White - North American (e.g. Canadian, American)
☐ Black - North American (e.g. Canadian, American)	☐ Mixed heritage (e.g. Black - African & White - North American)
☐ First Nations	Please specify:
☐ Indian - Caribbean (e.g. Guyanese with origins in India)	☐ Other(s): Please specify:
☐ Indigenous/Aboriginal - not included elsewhere	☐ Do not know
☐ Inuit	☐ Prefer not to answer

What is your sexual orientation? Choose ONE. ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian

☐ Queer (a term used by people who do not follow common sexual orientations) ☐ Do not know ☐ Prefer not to answer

☐ Two-Spirit (a term used by Aboriginal people) ☐ Other (Please specify):

What was your total family income before taxes last year? Choose ONE. ☐ Do not know ☐ Prefer not to answer

☐ $0 - $14,999	☐ $20,000 – $24,999	☐ $30,000 – $34,999	☐ $40,000 – $59,999
☐ $15,000 – $19,999	☐ $25,000 – $29,999	☐ $35,000 – $39,999	☐ $60,000 or more

How many people does this income support? ☐ Do not know ☐ Prefer not to answer