COMMUNITY PARTNERSHIPS AND SUPPORT SERVICES INTAKE FORM

Once completed, please email this form to CISS.Intake@york.ca or fax it to 905-830-5023
Please contact the Intake Representative at 1-877-464-9675 ext. 73433 if you have questions

SECTION 1 – GENERAL INFORMATION

Name of Person Completing Form: _____

Date of Referral (dd/mm/yyyy): _____

Referral Source: ☐ Self ☐ Family Member ☐ Caregiver ☐ Housing York Inc. ☐ Housing Access Unit

☐ Rent Supplement Program ☐ Agency/Other (please specify): _____

Referral Contact Email: _____ Referral Contact Phone: _____

Service/Program Being Referred to: ☐ Client Intervention and Support Services (CISS)
☐ Family Support Services
☐ Housing Support Services Social Worker

SECTION 2 –COMMUNITY PARTNERSHIPS AND SUPPORT SERVICES PROGRAM INFORMATION

Program Name	Description	Household
Client Intervention & Support Services (CISS)	York Region's Client Intervention and Support Services Program (CISS) can help older adults delay or avoid placement in long-term care by providing in-home assessments, case management, counselling, referrals, psychoeducation, and support advocating for a client's needs	Households must: • Live in York Region • Not live in long-term care • Be 60 years of age or over • Consent to service
Family Support Worker (FSW)	Helps households with financial literacy training, income benefits system navigation, financial assessments, and education	Households must: • Live in York Region • Not receive Ontario Works • Have financial or program navigation concerns • Consent to service
Housing Support Services (HSS)	Provides households with Social Worker supports that offer psycho-social assessments, case management, supportive counselling, referrals, and advocacy when managing situations, such as: • Mental health concerns • Complex family dynamics • Tenant conflict • System navigation • Eviction prevention • Hoarding, clutter, housekeeping	Households must: • Reside in a Housing York Inc. building • Consent to service and participate in service plans

SECTION 2 – CONSENT

To help you remain stably housed, The Regional Municipality of York (the "Region") is seeking your consent to collect, use, and share the personal information and personal health information contained in this form and its attachments (together, the "information") with representatives of the Region's Community and Health Services Department. Sharing means that we will disclose your information to representatives of the Region's Community and Health Services Department, and collect and use your information from those representatives.

We will only collect, use, and share your information with representatives of the Region's Community and Health Services Department for the purposes of determining your eligibility for services, and to assist in service planning and service navigation with respect to the following Support Services or Programs:

- Client Intervention and Support Services (CISS)
- Family Support Services (FSS)
- Social Worker/Housing Support Services

As the Region must share your information with the Community and Health Services Department to determine your eligibility for services, we will not be able to process your intake without your consent to share your information.

We will store your information in a secure database, and may use electronic communication, such as email or fax, to communicate your information to representatives of the Region's Community and Health Services Department. Electronic communication is not guaranteed to be secure. Some privacy risks include messages being intercepted by others in transit, and messages accidentally being sent to the wrong email address or fax number. In providing this consent, you accept the risks of electronic communication, and consent to the Region communicating your information to representatives of its Community and Health Services Department through electronic communication.

We will not share your information without your consent, unless required by law. For example, should we need to refer you to another agency, we would request your consent to share information with that agency.

In providing your consent, you agree and understand that:

- The decision to give or withhold consent is completely voluntary;
- You can change your preferences for information sharing or withdraw this consent at any time by notifying the Region;
- This consent remains valid while you are receiving services from the Region, unless you withdraw your consent by notifying the Region;
- If you withdraw your consent, that would not impact information already shared with your consent;
- You were given the opportunity to ask questions of a representative of the Region, and your questions were answered.

Do you consent to the collection, use and sharing of your information, as contained in this form and its attachments, between representatives of the Region's Community and Health Services Department for the purposes of assessing your eligibility for services, and assisting with service planning and navigation with respect to the Support Services or Programs identified above?

Client consent is provided: ☐ Yes ☐ No

Type of Consent Provided: ☐ Written ☐ Verbal Consent provided by: _____

Relationship to Client: _____ Date of Consent (dd/mm/yyyy): _____

Name of person giving consent: _____

SECTION 3 – CLIENT INFORMATION

Client Name:

Alias: Date of Birth:

Client Identifies Gender as:

☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Disclose

☐ Other, please specify:

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Current Address: Town/City:

Primary Phone Number: Can we leave a message? ☐ Yes ☐ No

Alternate Phone Number: Can we leave a message? ☐ Yes ☐ No

Email Address: Consent for Email ☐ Yes ☐ No

Language Spoken: Is an interpreter required? ☐ Yes ☐ No

Income Information (Select all that apply): ☐ Employment ☐ Ontario Works ☐ ODSP ☐ CPP

☐ GIS ☐ OAS ☐ Other (please specify):

Alternate Contact Name:

Alternate Contact Email:

Alternate Contact Phone: Can we leave a message with the Alternate Contact? ☐ Yes ☐ No

Preferred Alternate Contact Method: ☐ Phone ☐ Email

Can we discuss the referral with the Alternate Contact? ☐ Yes ☐ No

Relationship to Client:

☐ Primary Contact for Services ☐ Caregiver ☐ Emergency Contact ☐ Translator

☐ Substitute Decision Maker ☐ Power of Attorney ☐ Other

SECTION 4 –REASON FOR REFERRAL

- ☐ Advanced Care Planning/Future Planning
- ☐ Advocacy/System Navigation
- ☐ Crisis Intervention/Mental Health Concerns
- ☐ Complex Family Dynamics
- ☐ Conflict
- ☐ Eviction Prevention
- ☐ Financial Issues/Financial Improvement
- ☐ Hoarding/Clutter/Housekeeping
- ☐ Health Issues and Changes (Physical, Psychological, Emotional, Neurological)
- ☐ Elder Abuse

I have never lived with the abuser.

- ☐ Other (please explain):

Additional Information:

SECTION 5 – SERVICE/PROGRAM INFORMATION

Does the client receive additional support from other programs or services? ☐ Yes ☐ No
If yes, please list the programs or services. Please include Agency Name and Contact Information:

Does the client have an existing case manager? ☐ Yes ☐ No
If yes, please list the case manager's contact information, including the name of their agency:

Do the client's needs exceed the level of support received from these programs and services? ☐ Yes ☐ No
Additional Information:

Name of Person Completing Form

Date:

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To send this completed referral to Community Partnerships and Support Services, click on the Submit button.

SECTION 6 – FUNCTIONAL ASSESSMENT

TO BE COMPLETED FOR CLIENT INTERVENTION AND SUPPORT SERVICES PROGRAM INTAKE ONLY

1. Health Status

Has the client gone to the emergency department in the past year? ☐ Yes ☐ No

If yes, how many times? ☐ Reason: ☐

Has the client been admitted to the hospital in the past year? ☐ Yes ☐ No

If yes, how many times? ☐ Reason: ☐

Has the client had any recent falls? ☐ Yes ☐ No

If yes, how many times? ☐ Reason: ☐

2. Social Support

Is the client socially active? E.g., with family, friends, faith community or service clubs? ☐ Yes ☐ No

If yes, please describe: ☐

3. Functional Independence (Activities of Daily Living):

Does the client need help with any of the following?

Bathing	☐ Yes	☐ No	☐ Unknown	**Toileting**	☐ Yes	☐ No	☐ Unknown
Dressing	☐ Yes	☐ No	☐ Unknown	**Foot Care**	☐ Yes	☐ No	☐ Unknown
Eating	☐ Yes	☐ No	☐ Unknown	**Mobility**	☐ Yes	☐ No	☐ Unknown

If yes, list the aids used: ☐

4. Instrumental independence (IADL):

Does the client need help with any of the following?

Meal Preparation	☐ Yes	☐ No	☐ Unknown	**Housekeeping**	☐ Yes	☐ No	☐ Unknown
Laundry	☐ Yes	☐ No	☐ Unknown	**Transportation**	☐ Yes	☐ No	☐ Unknown
Managing Money/ Finances	☐ Yes	☐ No	☐ Unknown	**Medication Management**	☐ Yes	☐ No	☐ Unknown

5. Environmental Considerations

Unsafe Living Conditions	☐ Yes	☐ No	☐ Unknown	**Contagious Illness**	☐ Yes	☐ No	☐ Unknown
Hoarding	☐ Yes	☐ No	☐ Unknown	**Pets**	☐ Yes	☐ No	☐ Unknown
Bed Bugs	☐ Yes	☐ No	☐ Unknown	**Smokers**	☐ Yes	☐ No	☐ Unknown

6. Additional Help:

Does the Client need help with anything else (e.g., shopping, going to the doctor's office, arranging appointments, etc.): ☐ Yes ☐ No (If yes please provide a description): ☐

SECTION 6 – FUNCTIONAL ASSESSMENT CONT.

TO BE COMPLETED FOR CLIENT INTERVENTION AND SUPPORT SERVICES PROGRAM INTAKE ONLY

7.Health Conditions

Does the client have any of the following health conditions?

Arthritis	☐ Yes	☐ No	☐ Unknown	**Heart attack**	☐ Yes	☐ No	☐ Unknown
Cancer	☐ Yes	☐ No	☐ Unknown	**Heart disease**	☐ Yes	☐ No	☐ Unknown
Diabetes	☐ Yes	☐ No	☐ Unknown	**High blood pressure**	☐ Yes	☐ No	☐ Unknown
Memory Problems	☐ Yes	☐ No	☐ Unknown	**Kidney disease**	☐ Yes	☐ No	☐ Unknown
On Oxygen	☐ Yes	☐ No	☐ Unknown	**Osteoporosis**	☐ Yes	☐ No	☐ Unknown
Parkinson's	☐ Yes	☐ No	☐ Unknown	**Mental Health**	☐ Yes	☐ No	☐ Unknown
Lung Disease/ Asthma	☐ Yes	☐ No	☐ Unknown	(If yes, please specify):			
Emphysema/ COPD	☐ Yes	☐ No	☐ Unknown	**Stroke**	☐ Yes	☐ No	☐ Unknown

Other:

Is the client taking any medications for the above conditions? ☐ Yes ☐ No

8. Does the client have any of the following impairments?:

Visual ☐ Yes ☐ No ☐ Unknown **Speech** ☐ Yes ☐ No ☐ Unknown

Hearing ☐ Yes ☐ No ☐ Unknown

Comments:

9. Family Doctor Contact Information

Family Doctor's Name:

Phone Number:

Fax Number:

☐ Unknown ☐ Not Available

10. Psychiatrist Information (if available)

Psychiatrist's Name:

Phone Number:

Fax Number:

☐ Unknown ☐ Not Available

Name of Person Completing Assessment: Date:

Please attach any additional information that may assist with clinical treatment planning and service navigation

To send this completed referral to Community Partnerships and Support Services, click on the Submit button at the bottom of the form.

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