Canadian Mental Health Association
Kelowna
Mental health for all

WILLOWBRIDGE TRANSITIONAL HOUSING REFERRAL FORM

OFFICE USE ONLY
RECEIVED:

FAX COMPLETED FORM TO 778-478-0644

***Prior to submitting this form, please call the Operations Coordinator at 778-478-0244 for vacancy info*.** Referrals will not be accepted if this step is not completed. Referrals must be made by the service provider most familiar with the applicant's history; this service provider must be currently working with the applicant, and must continue to do so if the applicant is accepted into the program.

REFERRAL INFORMATION			
DATE OF INITIAL CALL TO ADMINISTRATION		DATE REFERRAL SUBMITTED	
REFERRING AGENT NAME & TITLE			
AGENCY / ORGANIZATION			
TELEPHONE		EMAIL	

APPLICANT INFORMATION					
NAME (LAST, FIRST, MI)					
ALIAS (STREET NAME)		❑ MALE ❑ FEMALE ❑ TRANSGENDER			
DATE OF BIRTH	DAY / MONTH / YEAR	AGE		PHONE	
ETHNICITY	❑ CAUCASIAN ❑ FIRST NATIONS ❑ INUIT ❑ MÉTIS ❑ OTHER ______				
FAMILY STATUS	❑ SINGLE ❑ COUPLE ❑ FAMILY ______ (TOTAL NUMBER) ❑ HEAD OF FAMILY (ONE PER FAMILY)				

ADDITIONAL COMMUNITY SUPPORTS			
PROBATION OFFICER		PHONE	
PAROLE OFFICER		PHONE	
MENTAL HEALTH CLINICIAN		PHONE	
A & D CLINICIAN		PHONE	
FAMILY PHYSICIAN		PHONE	
PSYCHIATRIST		PHONE	
OTHER		PHONE	

APPLICANT INFORMATION (CONTINUED)

SOURCE OF INCOME *SELECT ALL THAT APPLY*	❑ NONE ❑ EMPLOYMENT ❑ EMPLOYMENT INSURANCE (EI) ❑ INCOME ASSISTANCE (IA) ❑ INCOME ASSISTANCE – PERSONS WITH PERSISTENT MULTIPLE BARRIERS (PPMB) ❑ INCOME ASSISTANCE – PERSONS WITH DISABILITIES (PWD)	❑ CANADA PENSION PLAN (CPP) ❑ OLD AGE SECURITY (OAS) ❑ INAC BAND ❑ VOLUNTEER/WORK FOR INCOME TOP-UP ❑ WCB ❑ OTHER: ____________________
CURRENT LIVING SITUATION	❑ HOMELESS (ABSOLUTE) ❑ STAYING WITH FAMILY / FRIENDS (RELATIVE HOMELESS) ❑ INADEQUATE ACCOMMODATION (LACKING SOME BASIC NEEDS) ❑ UNSAFE ACCOMMODATION (VIOLENCE, DRUG USE, ETC)	❑ HOSPITAL – AWAITING DISCHARGE ❑ DETOX / RESIDENTIAL TREATMENT ❑ RECOVERY / MH GROUP HOME ❑ MOTEL ❑ PENDING EVICTION ❑ AGING OUT OF FOSTER CARE SYSTEM, ETC. ❑ OTHER ____________________

HOW LONG HAS APPLICANT BEEN HOMELESS (ABSOLUTE)?	❑<1 MONTH ❑ 1-6 MONTHS ❑ 6-12 MONTHS ❑ 1-3 YEARS ❑ 3+ YEARS ❑ N/A		
HOW LONG HAS APPLICANT LIVED IN THIS COMMUNITY?	❑ <3 MONTH ❑ 1-3 YEARS ❑ 3+ YEARS		
HAS THE APPLICANT BEEN INCARCERATED IN PAST	❑ YES ❑ NO ❑ DON'T KNOW	ON PROBATION? ❑ YES ❑ NO ❑ DON'T KNOW	ON PAROLE? ❑ YES ❑ NO ❑ DON'T KNOW
EMERGENCY CONTACT NOT SERVICE PROVIDER		PHONE	

HEALTH AND TREATMENT HISTORY

DOES APPLICANT HAVE ANY PHYSICAL HEALTH ISSUES?	❑ YES ❑ NO ❑ SUSPECTED / POSSIBLE ❑ DON'T KNOW	
PHYSICAL DISABILITY	❑ PERMANENT ❑ TEMPORARY MOBILITY LIMITATION	DESCRIBE:
PRIMARY HEALTH CARE	❑ ACUTE HEALTH CARE ISSUES (EG: SEVERE BLISTERS / SORES ON FEET) ❑ CHRONIC HEALTH CARE ISSUES (EG: DIABETES)	DESCRIBE:
OTHER STATED HEALTH CARE ISSUES *SELECT ALL THAT APPLY*	❑ FASD ❑ ACQUIRED BRAIN INJURY ❑ COGNITIVE / DEVELOPMENTAL DISABILITY ❑ HISTORY OF SEIZURES ❑ VISUAL IMPAIRMENT ❑ HEARING IMPAIRMENT ❑ OTHER	DESCRIBE:

SUBSTANCE USE AND MENTAL HEALTH HISTORY			
IS APPLICANT **CURRENTLY** USING ALCOHOL AND/OR OTHER SUBSTANCES?	❑ YES ❑ NO	DOES APPLICANT HAVE A **HISTORY** OF SUBSTANCE MISUSE?	❑ YES ❑ NO
IF **HISTORY** OF SUBSTANCE USE, HOW LONG HAS APPLICANT BEEN ABSTINENT?			
STATED ADDICTIONS (WHERE APPLICABLE)	❑ CRACK ❑ COCAINE ❑ CRYSTAL METH ❑ HEROIN ❑ ALCOHOL ❑ ALCOHOL SUBSTITUTES ❑ MARIJUANA ❑ OTHER ____________		
OBSERVED ADDICTIONS (WHERE APPLICABLE)	❑ CRACK ❑ COCAINE ❑ CRYSTAL METH ❑ HEROIN ❑ ALCOHOL ❑ ALCOHOL SUBSTITUTES ❑ MARIJUANA ❑ OTHER ____________		
HAS THE APPLICANT RECEIVED TREATMENT?	❑ YES ❑ NO	IF YES, WHEN: ____________ WHERE: ____________	
MEDICATIONS (PRESCRIBED OR OTC)	❑ YES ❑ NO IF YES, PLEASE LIST ALL:		
DOES APPLICANT HAVE ANY MENTAL HEALTH ISSUES?	❑ YES ❑ NO ❑ SUSPECTED / POSSIBLE ❑ DON'T KNOW		
STATED DIAGNOSES (WHERE APPLICABLE)	❑ DEPRESSION / ANXIETY ❑ ADHD ❑ PSYCHOSIS WITH DRUG USE ❑ BIPOLAR DISORDER ❑ SCHIZOPHRENIA ❑ OTHER: ____________	DETAILS:	
OBSERVED BEHAVIOURS (WHERE APPLICABLE)	❑ HALLUCINATIONS ❑ PARANOIA ❑ SELF-HARM ❑ VIOLENT OUTBURSTS ❑ TALKING TO SELF ❑ OTHER: ____________	DETAILS:	
OTHER IMPORTANT HEALTH INFORMATION (TYPE AND LENGTH OF TREATMENT, SYMPTOMS TO WATCH FOR ETC.)			

WHAT IS PREVENTING APPLICANT FROM SECURING HOUSING? *SELECT ALL THAT APPLY*	❑ BEHAVIOUR NOT CONDUCIVE TO LIVING WITH OTHERS ❑ HYGIENE ISSUES ❑ ACTIVE IN ADDICTIONS ❑ PETS ❑ NO REFERENCES ❑ CREDIT STATUS	❑ LANGUAGE BARRIERS ❑ MOBILITY LIMITATIONS / WHEELCHAIR ACCESS ❑ INCOME / MONEY / FINANCE RELATED ❑ MISSING IDENTIFICATION ❑ LACK OF SAFE, AFFORDABLE HOUSING ❑ OTHER: ______________

OTHER HISTORY

DOES APPLICANT HAVE ALLERGIES?	❑ YES ❑ NO ❑ DON'T KNOW	IF YES, DESCRIBE TREATMENT:
DOES THE APPLICANT'S CURRENT SITUATION INVOLVE DOMESTIC OR OTHER VIOLENCE?	❑ YES ❑ NO ❑ DON'T KNOW	DETAILS:

LIFE SKILLS ASSESSMENT	APPLICANT IS ABLE TO PREPARE MEALS	❑ YES ❑ NO ❑ DON'T KNOW
	APPLICANT IS ABLE TO MAINTAIN PERSONAL HYGIENE	❑ YES ❑ NO ❑ DON'T KNOW
	APPLICANT IS ABLE TO MAINTAIN LIVING QUARTERS	❑ YES ❑ NO ❑ DON'T KNOW
	APPLICANT HAS A HISTORY OF HOARDING	❑ YES ❑ NO ❑ DON'T KNOW
	APPLICANT COLLECTS BOTTLES/HAS A SHOPPING CART	❑ YES ❑ NO ❑ DON'T KNOW

MOBILITY	WHEELCHAIR	❑ YES ❑ NO	IF SO, IS IT USED INSIDE THE HOME? ❑ YES ❑ NO
	SCOOTER	❑ YES ❑ NO	

WHY ARE YOU REFERRING YOUR CLIENT TO WILLOWBRIDGE?	

AUTHORIZATION FOR RELEASE OF INFORMATION

To be reviewed and signed by the Applicant

In order to facilitate your application to the Willowbridge Transitional Housing Program, a service provider will be completing the referral package and documenting some of your personal information on your behalf. The information gathered will remain confidential and is collected and protected according to the *Personal Information Protection Act* (PIPA) of Canada.

The Kelowna Branch of the Canadian Mental Health Association (CMHA) will protect your personal information and only use this information in accordance with the law. Referral packages received where the Applicant is not accepted will be destroyed within four weeks of receipt. No personal information will be kept on file, as our program does not keep a waiting list.

I have read and understand the above information.

APPLICANT SIGNATURE (OR PERSON AUTHORIZED TO SIGN FOR APPLICANT) ______________________________

APPLICANT NAME (PRINT) ______________________________

REFERRING AGENT SIGNATURE ______________________________

REFERRING AGENT NAME (PRINT) ______________________________

DATED THIS ____________ **DAY OF** ________________ **20** ___

This authorization for release of information is in effect for a period of one year from the date above.

PROGRAM PARTICIPANT CODE OF CONDUCT

To be reviewed and signed by the Applicant. Upon acceptance into the Willowbridge Transitional Housing Program, Applicant becomes a Program Participant.

1. Curfew is from 10:00pm until 5:00am daily. As a Program Participant I will be in the building at that time. If for some extraordinary reason I am unable to be at the building during these hours I will call to advise staff.
2. As a Program Participant of the Willowbridge community, I agree to contribute towards the maintenance and upkeep of the building and grounds (community contributions).
3. I will keep appointments with Willowbridge staff, CMHA staff and community service providers. If I am unable to attend, I will give as much notice as possible.
4. I will endeavour to speak respectfully to all staff and residents. If there is conflict I will seek out assistance when required to resolve the situation.
5. I will make every effort to work on my goals and follow through on my commitments.
6. I will come to group activities on time and prepared.
7. I will be a good neighbour by ensuring the volume of TV or other noise is kept to a minimum. I will not slam doors, shout or cause disturbances or use the stairs after 10:00pm.
8. I will report to the staff any illegal activities I see in or around the building.
9. I will not bring illegal drugs/drug paraphernalia, alcohol/alcohol bottles or weapons into Willowbridge. If I have used any substances, I will enter the building and go into my individual unit quickly and quietly. If this is a relapse, I will respect myself enough to seek out assistance the next day to help in addressing the matter.
10. I understand and accept the consequence of potential immediate eviction should I choose to bring alcohol, weapons or drugs into the building.
11. I will not gossip about other residents. I am here to grow and learn and so are others. I will respect their right to privacy, safety and serenity.
12. I will keep my room neat and tidy. I will ask for help if I am having difficulty with the upkeep, or if maintenance is required. <u>I understand that my room will be inspected monthly for health & safety.</u>
13. If I smoke I will only use the designated outdoor smoking area.
14. I will respect the surrounding neighbourhood by not littering or taking short-cuts through their property.
15. In any public space throughout Willowbridge, I will ensure to leave things neat and tidy for the next person. This includes, but is not limited to, the kitchen, bathrooms, community room and smoking area.

As a Program Participant I agree to follow this Code of Conduct and accept responsibility for my growth and development while participating in the Willowbridge Transitional Housing Program.

APPLICANT SIGNATURE ____

DATED THIS ____________ **DAY OF** ____________________ **20** ____

WILLOWBRIDGE TRANSITIONAL HOUSING
THREE-WAY AGREEMENT

The purpose of this document is to ensure that the Referring Agent and the Applicant have an understanding of, and commitment to, the program requirements. Upon acceptance into the Willowbridge Transitional Housing Program, Applicant becomes a Program Participant.

UPON ACCEPTANCE, APPLICANT COMMITS TO:

1. Adhere to the Willowbridge Code of Conduct;
2. Work proactively with support team including Willowbridge staff and service providers to set goals and address barriers;
3. Communicate with staff regarding any issues or challenges that may arise;
4. Contribute to maintenance and upkeep of the building and grounds;
5. Agree to the safe storage of medication, when necessary.

APPLICANT INITIALS ____________________

UPON ACCEPTANCE OF APPLICANT, REFERRING AGENT COMMITS TO:

1. Follow up with, assist and advocate on behalf of the Program Participant for the duration of his/her stay at Willowbridge;
2. Provide Willowbridge staff with relevant information regarding the Program Participant's strengths and challenges;
3. Identify and address the attainable needs of the Program Participant;
4. Provide practical support to the Program Participant during the following transitional phases:
   - from homelessness, or risk of homelessness into the program
   - from the program into permanent housing
5. Work with Program Participant and Willowbridge staff to formulate an Individualized Service Plan and; to be proactive in ensuring the Program Participant is working towards goals;
6. Anticipate, identify and actively engage Program Participant in securing appropriate long-term housing when Program Participant is ready to transition.

If unable to carry out the above requirements, an alternate worker must be assigned by the Referring Agent. This individual will act on behalf of the Referring Agent, and will be made aware of his or her obligations to the Program Participant and to the Willowbridge Transitional Housing Program (above).

REFERRING AGENT INITIALS ____________________

NAME OF ALTERNATE WORKER ____
(WHERE APPLICABLE)

AGENCY/ORGANIZATION ______________________________ **TELEPHONE** ____________________

UPON ACCEPTANCE OF APPLICANT, WILLOWBRIDGE STAFF COMMIT TO PROVIDE:

1. Proactive, regular contact regarding Program Participant;
2. A collaborative relationship based on respect;
3. A Program Participant and community-centred approach;
4. A safe, supportive and accountable environment;
5. Access to available programming that meets the individualized needs of the Program Participant;
6. Common purpose in the exchange of confidential information.

We, the undersigned, agree to our respective commitments, as outlined above.

APPLICANT SIGNATURE (OR PERSON AUTHORIZED TO SIGN FOR APPLICANT) ______________________ **DATE** __________

APPLICANT NAME (PRINT) ______________________

REFERRING AGENT SIGNATURE ______________________ **DATE** __________

REFERRING AGENT NAME (PRINT) ______________________

To be completed upon receipt of referral package

WILLOWBRIDGE STAFF SIGNATURE ______________________ **DATE** __________

WILLOWBRIDGE STAFF NAME (PRINT) ______________________

WILLOWBRIDGE STAFF TITLE ______________________

APPLICATION INSTRUCTIONS

Please fax completed package to Willowbridge Administration at 778-478-0644. Each referral is assessed on a case-by-case basis; no waiting list is maintained. A copy of this referral package will be kept on file for 3 months from date of receipt. If applicant is not accepted, all documentation will be destroyed.