Wendat Community Programs
Adult Mental Health Services
705 526-1305
Fax 705 526-9248

WENDAT

P.O. Box 832, 237 Second St.
Midland ON L4R 4P4
www.wendatprograms.com
info@wendatprogrmas.com

Case Management Program Application Form

Date	Referral Source	Referral phone #	Referral email

Client name			
First	**Middle**	**Last**	**Alias**
Health Card #:		**DOB:**	

Address	Phone #	Alternate Phone #	Email
Preferred method of communication:		**Can we leave a message?** ☐ **yes** ☐ **no**	
Language Spoken at Birth:		**Preferred Language:**	
Cultural Identification: ☐ Indigenous ☐ Metis ☐ other_____		**Highest Educational Level:**	
Gender: ☐ Prefer not to disclose ☐ female ☐ male ☐non-binary ☐ other_____		**Mental Health Diagnosis**: Primary:_____	
Marital Status: ☐ married ☐ single ☐ common law		Secondary:_____	

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Next of Kin:	**Emergency Contact Person:**
Family Doctor:	**Psychiatrist:**
Other Service Providers:	**Specialists:**
Medical issues:	**Chronic Ilnesses:**
Current Treatments:	**Current Medications:**

Current Challenges:

□Threat to self	□Threat to others	□Attempted suicide
□Physical abuse	□Sexual abuse	□Educational
□Housing	□Legal	□Medical
□Symptoms of mental illness	□Social/interpersonal	□Occupational/employment
□Problems with relationships	□Substance abuse	□Addictions
□Activities of daily living	□Need substitute decision maker	□Other:

Do you have a documented crisis plan?	**Yes**	**No**	**Where:**
Have you completed an OCAN	**Yes**	**No**	**Where:**
Are you on a community treatment order (CTO)	**Yes**	**No**	

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When did you first begin experiencing mental illness?	**How old were you when you had your fist psychiatric hospitalization?**

How many times have you been hospitalized in the past two years?		
Name of hospital	**Date Admitted**	**Date of Discharge**

Employment History and Status:

□ Employed full time	□ employed part time	□ able to work but unemployed
□ student or retraining	□ retired	□ unable to work
□ self-employed	□ volunteer	Other:

Have you engaged in paid employment in the last six months? □ yes □ no

Income Source(s)	**Monthly Income:**

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Please rate yourself on the following:

Budgeting:

Poor									**excellent**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Paying Rent on Time:

Poor									**excellent**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Cooking:

Poor									**excellent**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Shopping for Groceries:

Poor									**excellent**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Doing Laundry

Poor									**excellent**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What Goals do you hope to achieve in the next three months:

_____

What Goals do you hope to achieve in the next six months:

_____

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Housing Information:

Is your current living arrangement satisfactory? □ yes □ no

Have you experienced homelessness in the past six months? □ yes □ no

What is your current Living Situation?

□ Private market rent	□ private subsidized rent	□ Rooming house	□ Long term care	□ Home for Special Care
□ Municipal Non-Profit Housing	□ Private Non-Profit housing	□ Group Home	□ Homeless	□ Shelter
□ Psychiatric Hospital	□ General Hospital	□ Supportive Housing	□ Specialty Hospital	□ Chronic Care Home
□ Correctional Facility	□ Retirement Home	□ Unknown	Other:	

Information in this application will be used to collect data for program evaluation purposes. Applicant names will not be used in this process. By signing below, the applicant consents to the use of this information for evaluation purposes. Applicants may withdraw their consent at any time. Participating or refusing to participate in data collection will not affect services available to the applicant.

May we use this information for program evaluation purposes: □ yes □ no

_____ _____

Applicant's signature date

Please return completed applications to the Program Supervisor, Case Management by fax to 705 526-9248 or mail to p.o. box 832, 237 Second St. Midland ON L4R 4P4. The Program Supervisor is available Monday to Friday 8 am to 4 pm at 705 526-1305 ext 245.

Office Use Only	
Referral Date:	Status:
Intake outcome:	Service Entry Date: