

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

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? <input type="checkbox"/> yes <input type="checkbox"/> no	
Language Spoken at Birth:		Preferred Language:	
Cultural Identification: <input type="checkbox"/> Indigenous <input type="checkbox"/> Metis <input type="checkbox"/> other _____		Highest Educational Level:	
Gender: <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> non-binary <input type="checkbox"/> other _____		Mental Health Diagnosis:	
Marital Status: <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> common law		Primary: _____ Secondary: _____	

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Next of Kin:		Emergency Contact Person:	
Family Doctor:		Psychiatrist:	
Other Service Providers:		Specialists:	
Medical issues:		Chronic Illnesses:	
Current Treatments:		Current Medications:	
Current Challenges:			
<input type="checkbox"/> Threat to self	<input type="checkbox"/> Threat to others	<input type="checkbox"/> Attempted suicide	
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Educational	
<input type="checkbox"/> Housing	<input type="checkbox"/> Legal	<input type="checkbox"/> Medical	
<input type="checkbox"/> Symptoms of mental illness	<input type="checkbox"/> Social/interpersonal	<input type="checkbox"/> Occupational/employment	
<input type="checkbox"/> Problems with relationships	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Addictions	
<input type="checkbox"/> Activities of daily living	<input type="checkbox"/> Need substitute decision maker	<input type="checkbox"/> 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 first psychiatric hospitalization?
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How many times have you been hospitalized in the past two years?		
Name of hospital	Date Admitted	Date of Discharge

Employment History and Status:

<input type="checkbox"/> Employed full time	<input type="checkbox"/> employed part time	<input type="checkbox"/> able to work but unemployed
<input type="checkbox"/> student or retraining	<input type="checkbox"/> retired	<input type="checkbox"/> unable to work
<input type="checkbox"/> self-employed	<input type="checkbox"/> 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?

<input type="checkbox"/> Private market rent	<input type="checkbox"/> private subsidized rent	<input type="checkbox"/> Rooming house	<input type="checkbox"/> Long term care	<input type="checkbox"/> Home for Special Care
<input type="checkbox"/> Municipal Non-Profit Housing	<input type="checkbox"/> Private Non-Profit housing	<input type="checkbox"/> Group Home	<input type="checkbox"/> Homeless	<input type="checkbox"/> Shelter
<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> General Hospital	<input type="checkbox"/> Supportive Housing	<input type="checkbox"/> Specialty Hospital	<input type="checkbox"/> Chronic Care Home
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Retirement Home	<input type="checkbox"/> 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 1245.

Office Use Only

Referral Date:

Status:

Intake outcome:

Service Entry Date: