APPLICATION FORM
Dual Diagnosis Case Management and
Dual Diagnosis & Justice Case Management

Cota offers a wide array of services to people in need within our community. To view a comprehensive list of our services, their respective eligibility criteria, and how to make referrals to them, please visit our website at **https://cotainspires.ca/**

Note: This Application Form is only intended for the services listed in Part 1 below, which presently require direct referrals to us, rather than applications through a coordinated access or priority referral mechanism.

When completing this application form please answer as many questions as you can. Please also read the Declaration and Consent section on page 8 and sign the application form. The confidentiality of the information you provide will be respected in adherence with the Personal Health Information Privacy Act (PHIPA). You can mail, fax, or hand deliver the completed application form to:

Attn: Intake at Cota
550 Queen Street East, Suite 201,
Toronto, ON M5A 1V2
Tel: (416) 785-9230 | Fax: (416) 785-9358
E-mail: intake@cotainspires.ca

PART 1

Please check the box of the program for which you wish to apply.

Date Referral Was Submitted (DD/MM/YYYY):_____

☐	**Dual Diagnosis Case Management** *Available to individuals (16+ years old) living with a co-occurring developmental disability (documented by a cognitive assessment or note from a medical practitioner) and a diagnosis of serious mental illness (substance use disorder alone are not sufficient as a mental health diagnosis) and who are living in the city of Toronto (inclusive of Etobicoke, Scarborough, East York, North York and downtown Toronto).*
☐	**Dual Diagnosis & Justice Case Management** *Applicants must fulfill the eligibility criteria as outlined as above in "Dual Diagnosis Case Management" and must also be involved with, or be at risk of involvement with, the justice system. Referrals are accepted from designated priority referral sources including Mental Health Court Support Services, Police, Probation/Parole, the Law & Mental Health program at CAMH, Ontario Shores' Forensic Unit and other funded Mental Health & Justice services.*

PART 2

A. DIAGNOSIS

1. Do you have a medical assessment/note confirming a diagnosis of developmental disability?
(e.g. cognitive assessment or note from a medical practitioner)

☐ Yes ☐ No

Note: We will require medical documentation of a diagnosis of developmental disability before we can initiate service. You do not need to attach the assessments/reports or medical notes with this application form, but we will need to review them prior to making an admission decision.

2. Do you have a medical assessment/report confirming a diagnosis of a serious mental illness?

☐ Yes ☐ No

Note: A diagnosis of serious mental illness in not required before we initiate service and you do not need to include the assessments/reports or medical notes in the application itself. If a diagnosis is not available, please include a description of the functional challenges you are experiencing relating to your mental health and the duration of time you have been experiencing them in Section F – Applicant's Support Needs.

B. JUSTICE SYSTEM INVOLVEMENT

Note: If you are not applying for Dual Diagnosis & Justice Case Management please skip forward to Section C

If you are applying for Dual Diagnosis & Justice Case Management, please list the priority referral source that you are being referred from/involved with *(e.g. Mental Health Court Support Services, Police, Probation/Parole, the Law & Mental Health program at CAMH, Ontario Shores' Forensic Unit and other funded Mental Health & Justice services).*

Please also list pertinent offence dates, types of involvement (including charges) and outcome.

C. CONTACT INFORMATION

First & Last Name

Date of Birth (DD/MM/YYYY)

Gender

☐ Male ☐ Gender Non-Binary ☐ Trans-Male ☐ Other Gender Identity

☐ Female ☐ Do Not Know ☐ Trans-Female ☐ Prefer Not to Answer

Ontario Health Card Number

☐ I don't have an Ontario Health Card

☐ I don't know my Ontario Health Card number

Street Address

Number **Street Name** **Apt. #** **City** **Province** **Postal Code**

☐ No Fixed Address

Closest Major Intersection

Area of The City

☐ North York ☐ East York ☐ Downtown Toronto ☐ Scarborough ☐ Etobicoke

Phone Number (include extension if applicable)

Alternative Contact
If you do not have a phone or are otherwise difficult to reach, is there someone with whom you are in regular contact that we can call in order to reach you?

First & Last Name

Phone Number (include extension if applicable)

Can a message be left at this number?

☐ Yes

☐ No

Relationship or Organization

D. REFERRAL SOURCE INFORMATION

Please complete if not a self-referral

Referrer's Name

Title

Agency

Phone Number (include extension if applicable)

Fax Number

Street Address

Number | Street Name | Apt. # | City | Province | Postal Code

Email Address	
Relationship to Applicant	**How long have you known the applicant?**

E. INFORMATION TO HELP US UNDERSTAND YOU BETTER

Do you speak English?

☐ Yes

☐ No

☐ Some

What is your first language?

☐ English

☐ French

☐ Other: _____

What is your preferred language?

☐ English

☐ French

☐ Other: _____

Do you have a Substitute Decision Maker?

☐ Yes

☐ No

What is their relationship to you?

Do you have a Power of Attorney?

☐ Yes

☐ No

If yes, who is your Power of Attorney?

If yes, for what?

☐ Personal Care

☐ Finances

☐ Both Personal Care and Finances

☐ I don't know

F. HEALTH INFORMATION

What are your support needs? *Select all that apply.*

☐ Acquired Brain Injury ☐ Substance Use Disorder ☐ Dementia (e.g. Alzheimer's Disease)

☐ Developmental Disability ☐ Mental Health Condition

Please describe the functional challenges you are experiencing in relation to you disability or diagnosis and how long you have been experiencing them.

Do you have any other health conditions or medical problems?
This includes allergies, seizures, diabetes or disabilities.

☐ Yes ☐ No ☐ Unknown

If yes, please specify:

Have you been diagnosed with an infectious illness?

☐ Yes ☐ No ☐ Unknown

If yes, please specify:

G. APPLICANT'S SUPPORT NEEDS

Applicant requests support with:

☐ Managing Specific Symptoms of Serious Mental Health Illness
☐ Providing Support with Daily Living Skills
☐ Finances
☐ Legal Issues
☐ Housing Needs
☐ Relationships
☐ Educational Opportunities
☐ Occupational/Employment/Vocational
☐ Substance Use Challenges

Managing/Reducing Risky Behaviour
(select all that apply below):

☐ *Threat to others/attempting suicide*
☐ *Aggression or violence (verbal/physical/sexual)*
☐ *Destruction of property (including fire-setting)*
☐ *Physical risk (e.g. falls)*
☐ *Wandering/roaming*
☐ *Other:* _____

Applicant's Comments Regarding Support Needs

Please briefly describe the reason(s) for your application. In which areas are you looking for support? (e.g. recovery goals, self-care, housing/household care, finances, daily activities/education/employment, relationships, social activities, other)?

Referral Source's Comments Regarding Support Needs

Please briefly describe the reason(s) for referral. What is the present difficulty and in which areas could the applicant benefit from support?

H. EXISTING SUPPORTS

Are you currently working with any other service providers?

☐ Yes ☐ No

If yes, please provide the following information on each service provider with whom you are working:

Agency	Name/Contact Person	Service(s) Received	Phone Number

YOUR DECLARATION & CONSENT

We **promise that the confidentiality of the information you have provided will be respected in accordance with all applicable legislation.** Please ***feel free to call us*** for more information on how your confidentiality will be preserved. By checking the boxes below and signing this application form, you agree to what is set out in the following statements. Please read it carefully before signing.

APPLICANT'S DECLARATION & CONSENT

I have done my best to ensure that the information provided in this application is correct.	☐ Yes	☐ No
I would prefer both my referrer and myself to be contacted for the initial assessment.	☐ Yes	☐ No
I understand that in order to determine my eligibility for individual support services the intake staff: • Will contact me for further information and to discuss and update me regarding my application. I give my permission for this. • May contact and share information with the Referrer (if any) who signs the Referrer's Statement below. I give my permission for this. • Contact and share information with the service providers listed on page 7 of this application form, except for (list exceptions, if any): _____ _____ I give my permission for this.	☐ Yes	☐ No
Applicant's Signature **Print Name**		
Date Signed (DD/MM/YYYY)		
I have chosen to provide verbal consent to all the items checked off above.	☐ Yes	☐ No
If you have chosen not to consent to any of the above statements, please explain:		

REFERRER'S STATEMENT

If another person is referring the applicant, that person (the referrer) must complete this section of the application. By signing this application form, the referrer agrees to what is set out in the statement below. Please read it carefully before signing.

Referrer's Statement
To the best of my knowledge, the information contained in this application is correct. I have discussed this application with the applicant, explained the role of Cota and the application process, and whenever possible, have completed this application together with the applicant.

Referrer's Signature	**Print Name**
Date Signed (DD/MM/YYYY)	