APPLICATION FORM
Psychogeriatric 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 for Cota's Psychogeriatric Case Management service, which presently requires direct referrals to us, rather than applications through a coordinated access or priority referral mechanism. The eligibility criteria for this service is as follows.

Eligibility Requirements

Cota's Psychogeriatric Case Management Service is available to individuals who are:
• Housed
• Either:
  ○ 65 years of age or older and live with a mental health diagnosis and dementia
  ○ Of any age with an early onset diagnosis of dementia with complex care needs (e.g. ADL, IADL) that are affecting their functioning
 	
Please note we will require medical documentation of a diagnosis or dementia before we can initiate service.

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

APPLICATION

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

A. DIAGNOSIS

Do you have any medical assessments/reports confirming a diagnosis of dementia?
(e.g. General Memory Assessment, MOCA, RAI Assessments, Home Care, Geriatrician Assessments, etc.)

☐ Yes ☐ No

Note: You do not need to include the medical assessment/report in the application itself.

B. 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 ☐ DowntownToronto ☐ 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

C. 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?**

D. 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: _____

Substitute Decision Maker & Power of Attorney Information

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

Justice Involvement

Are you currently involved with the criminal justice system?
Please note this will not affect your ability to receive service. It is to help us better direct your application.

☐ Yes ☐ No

If yes, please indicate dates, types of involvement (including charges), and outcome:

E. 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)	