

Margaret Frazer House

(416)463-1481

301 BroadView Avenue
Toronto Ont. M4M2G8

FAX # (416) 461-4866

Dear:

Re: Consent for Disclosure

We ask that this application be filled out completely and sent to Margaret Frazer House. Please print all the information in ink. In addition, you need to read and understand the **Consent for Disclosure of Personal Health Information** forms. These should then be filled out, signed, and included with your application.

Yours truly,

Alix Hall
Intake Worker

INTRODUCTION

Margaret Frazer House is a residence for eleven women who have histories of psychiatric issues and who range in age from 18 to 64 years. We provide a setting where women learn to live co-operatively, and we encourage their independence.

Our staff operates from an inclusive perspective and we provide 24-hour support to residents. Presently, our length of stay is up to 2 years. We assist residents in finding suitable permanent housing.

While living at the house, women are encouraged to be involved in community programs. They are expected to share in house chores and to participate in general house routines (shopping, cooking, etc.).

After we receive a completed application, an interview is scheduled. This will be followed by a supper date at the house so the applicant can meet other residents, and vice-versa. The application is then reviewed by staff and if the woman is accepted, a move-in date will be set. The first four weeks of a woman's stay are probationary; then she is formally accepted to the house.

ADMISSION CRITERIA

1. Woman, aged 18 to 64.
2. Women must be recovering from mental health issues.
3. Has achieved a minimum of 3 month's sobriety.
4. Is able to provide basic self-care and hygiene.
5. Requires 24-hour support.
6. Must have a physical check-up before moving in.
7. Is in a state of transition, not on-going crisis.
8. Is not a danger to herself or others.

N.B. Applications without a fully completed and signed medical form will not be processed by Margaret's staff.

HOUSE POLICY AND DEFINITION OF BIGOTRY

Staff and residents at Margaret Frazer House must conform to the non-bigoted behaviour outlined on this page.

It is very important that all people be welcome and safe at Margaret Frazer House and that no one be hurt or made to feel inadequate based on someone else's bigotry.

This is a co-operative and non-violent house.

Bigoted behaviour will be addressed, and staff will provide education and support.

DEFINING BIGOTED BEHAVIOUR

Any behaviour that makes assumptions about other people based on their culture, religion, language, country of origin, sexuality, skin colour, or disability.

Making generalizations about groups or categories of people, even if one believes the statement to be a "positive" one – for example the statement, "Asian people are so polite/smart" etc. (the negative example being, "Asian people are such bad drivers.").

Imitating someone's accent when they are speaking English or making fun of their native language.

Using derogatory words to describe other groups of people or using words people have not chosen to define themselves.

APPLICATION FORM FOR MARGARET FRAZER HOUSE

DATE _____

APPLICANT'S NAME _____ PHONE _____

ADDRESS _____

AGE _____ DATE OF BIRTH _____

HEALTH CARD # _____ SIN _____

EMERGENCY CONTACT _____ PHONE _____

ADDRESS _____

RELATIONSHIP TO APPLICANT _____

PHYSICAL ILLNESSES OR DISABILITIES (epilepsy, diabetes, etc.) _____

ALLERGIES _____

SOURCE OF INCOME _____ AMOUNT _____

NAME OF INCOME MAINTENANCE WORKER _____ PHONE _____

REFERRING AGENCY _____

CONTACT PERSON _____ PHONE _____

POSITION _____

MEDICAL DOCTOR _____ PHONE _____

PSYCHIATRIST _____ PHONE _____

THERAPIST _____ PHONE _____

PSYCHIATRIC HISTORY

DATE OF LAST HOSPITAL ADMISSION _____

REASON FOR LAST ADMISSION _____

DATE OF FIRST ADMISSION _____

ANY OTHER ADMISSIONS? _____ HOW MANY? _____

TO WHICH HOSPITALS? _____

REASONS? _____

SUICIDE ATTEMPTS? _____ HOW MANY _____

WHEN? _____

SEVERITY _____

ARE YOU WILLING TO LIVE IN A CO-OPERATIVE SETTING? _____

WHAT ARE YOUR FEELINGS ABOUT LIVING IN SUCH A SETTING? _____

WHAT DO YOU SEE AS YOUR STRENGTHS? _____

WHAT DO YOU SEE AS YOUR WEAKNESSES? _____

DO YOU HAVE ANY DIFFICULTIES SLEEPING? _____ IF SO, HOW DO

YOU DEAL WITH THEM? _____

WHAT DO YOU LIKE TO DO IN YOUR SPARE TIME? _____

OTHER INTERESTS _____

SHORT TERM GOALS _____

LONG TERM GOALS _____

WHAT BENEFITS DO YOU THINK MARGARET'S COULD PROVIDE FOR YOU?

OTHER COMMENTS? _____

NAME _____ SIGNATURE _____

(PLEASE PRINT)

PHONE _____ EXT. _____

I NEED HELP WITH: (please specify)

1. FOOD - shopping; cooking; choosing healthy food; eating regularly; planning meals
2. MEDICATION - can't remember to take it regularly; having problems with side effects
3. HYGIENE - washing myself; keeping my teeth brushed; keeping myself supplied with clean clothes; keeping my room and personal space clean and tidy
4. MONEY - budgeting
5. GETTING AROUND - unfamiliar with Toronto; easily disoriented; don't know transit system; afraid of transit system; afraid of going outside
6. COMMUNITY PROGRAMS - don't know what's available; afraid to go to such programs; not interested in community programs (workshops, rehabilitation, day-care, school, job training)
7. FREE TIME - don't know what to do with myself when I have free time
8. PEOPLE - too isolated from family and/or friends; don't know how to meet people; afraid of people; hostile with other people
9. COMMUNICATION - difficulty reading and writing; difficulty talking
10. OTHER -- _____

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MEDICAL INFORMATION

NAME OF WOMAN REFERRED* _____

EVIDENCE OF: IMPETIGO? _____
 PARASITES? (i.e. lice, scabies) _____
 T.B. (TUBERCULOSIS)? _____
 DERMATOPHYTES? (i.e. pityriasis, tinea) _____
 HERPES? _____
 HEPATITIS? _____
 OTHER? _____

RELATED TREATMENT/MEDICATION _____

ADDITIONAL PERTINENT INFORMATION _____

PHYSICIAN'S SIGNATURE _____ Date _____

Name (please print) _____

Phone # _____ Ext. _____

**N.B. applications lacking a fully completed and signed medical form will not be
processed by Margaret's staff*

CASE MANAGEMENT AGREEMENT

We, at _____, agree that if
(name of hospital)

_____ is admitted to
(name of client)

MARGARET FRAZER HOUSE, we will:

1. Register _____ as an outpatient at this
(name of client)
hospital.
2. Provide on-going consultation and co-ordination, and participate in case conferences with staff as required.
3. Accept responsibility for relocating the client who must leave the housing program for reasons of unsuitability. It is understood that the program will provide consultative assistance in regard to identifying the housing requirements of the client.
4. Arrange financing for payment of rent and food; i.e. ODSP or Ontario Works. For the resident who will initially require Ontario Works, we agree to submit an application for ODSP prior to her moving into the above-named program.

Date: _____

Administrator or designate: _____
(signature)

Referring Psychiatrist: _____
(signature)

Outpatient Co-ordinator/worker/other _____
(signature)

(title)

Client's Health card # _____ Client's File # _____

We, at _____, agree that if
(name of hospital)

_____ is admitted to
(name of client)

MARGARET FRAZER HOUSE, we will:

1. Accept full responsibility for re-assessing and re-admitting the client should her psychiatric condition deteriorate to a point where her present behaviour is inappropriate for Margaret Frazer House.
 - a. If, upon re-assessment, we determine that the client is not in need of re-hospitalization, then the terms of the Case Management Agreement shall be in effect.
 - b. Should the resident be re-admitted to our hospital, we agree to notify Margaret Frazer House at least twenty-four (24) hours prior to the subsequent discharge of the client. Re-entry to the housing program will be negotiated in accordance with admission criteria of the housing program.

Date: _____

Administrator or designate: _____
(signature)

Referring Psychiatrist: _____
(signature)

Outpatient Co-ordinator/worker/other _____
(signature)

(title)

Client's Health Card # _____ Clients File # _____

