



RAPID RESPONSE OUTREACH SERVICES REQUEST FOR SERVICES FORM

11\12\06

The following can be completed by the individual requesting services, family and/or referring agency and returned to:

221 Wilson St., Thunder Bay, ON P7B 1M7

Tel: (807) 683-8200 Fax: (807) 683-8225 Web site: www.alphacourt.ca

PERSONAL INFORMATION	
Name of Person Being Referred:	Date of Birth: (Day, month, year)
Address:	Preferred Language
Postal Code:	Telephone #:
Alternate Contact:	Telephone #:
Health Card #:	
PSYCHIATRIC HISTORY: Have you been diagnosed with a mental illness? If yes:	
Primary Diagnosis:	Year diagnosed
Secondary Diagnosis (if applicable:)	Year diagnosed
ADDICTIONS: Do you have any addictions issues? Please describe.	
HOUSING NEEDS: Are you homeless or at risk of losing your housing? Please describe.	
Are you currently involved with the legal system? If yes, please describe.	
Are you currently receiving service from another agency for mental health or addictions problems? If yes, please provide names of agency.	
TYPE OF SUPPORT REQUESTED (Select all required)	
<input type="checkbox"/> Accessing employment or education, structuring daily activities <input type="checkbox"/> Assistance with self care (i.e. nutrition, medication, hygiene, clothing maintenance) <input type="checkbox"/> Assistance with daily living skills (i.e. managing finances, preparing meals, housekeeping, appointment keeping) <input type="checkbox"/> Education around diagnosis, symptom management <input type="checkbox"/> Developing formal and informal support networks <input type="checkbox"/> Accessing decent, affordable housing <input type="checkbox"/> Assistance with community involvement/participation (i.e. using public transit, accessing rehabilitation services/ social recreational programs) <input type="checkbox"/> Support, problem solving, advocacy <input type="checkbox"/> Aboriginal programming <input type="checkbox"/> Other:	

AUTHORIZATION

The applicant is aware and has given consent to submitting this document.

I, _____, wish to be considered for services provided by Alpha Court.
(Print Name)

Signed

Date

If an individual/agency has assisted the applicant with this document, please complete below.

Name (Please Print)

Relationship to Individual

Agency

Date

Pursuant to the *Federal/Provincial/Municipal Freedom of Information and Protection of Privacy Act*, I give my consent and authorization to ALPHA COURT NON-PROFIT HOUSING CORPORATION. For any issues with regard to privacy, please contact, Executive Director of Alpha Court Non-Profit Housing Corporation.

*New forms available at web site www.alphacourt.ca