ST. LEONARD'S PLACE PEEL
it's how we care

ALIGNING SENIORS
Against Poverty

Referral Form

Aligning Seniors Against Poverty (ASAP) is a St. Leonard's Place Peel initiative designed to alleviate the effects of poverty among senior men 55 and over, particularly those experiencing mental health and addictions

Client Basic Information

First Name: _____ Last Name: _____

OHIP#: _____ Phone Number:_____

D.O.B (MM/DD/YYYY) : _____ Age: _____ Gender: _____

Current Address: _____

Source of Income

Please select ALL that apply with a rough monthly estimate if possible.

Employed/ Self Employed ☐ Ontario Disability Support Program (ODSP) ☐
Unemployed/ Looking for work ☐ Employment Insurance (EI) ☐
Ontario Works (OW) ☐ Canada Pension Plan (CPP) ☐
Ontario Trillium Benefit (OTB) ☐ Disability Tax Credit ☐
Passport Funding (DSO) ☐ GAINS ☐ GST/HST ☐
Old Age Security (OAS) ☐ Other ☐ $ _____ /monthly income

Reason for Referral

Please select ALL that apply.

Employment Assistance ☐ Budgeting ☐ Applying for Subsidized Housing ☐
Filling Applications ☐ Filing your Taxes ☐ Applying for Long Term Care ☐
Housing Search ☐ Linkages to Addictions Services ☐ Linkages to Mental Health Services ☐
Financial Planning ☐ Supportive Housing ☐ Unsure of program ☐

Referral Source	Self ☐	Other (specify) ☐ _____	
	Agency ☐		
	Agency Name	**Agency Address**	**Agency Telephone Number**

Kindly scan and email the completed forms to ASAP@SLPP.CA

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Housing Situation - ***Please describe client's current housing situation, and any plans or applications submitted. Please list any relevant workers on the next page.***

Physical Health - ***Please describe client's current physical health, whether the client struggles with any physical disabilities and or any health-related information that should be known such as allergies. Please list any relevant workers on the next page.***

Mental Health- ***Please describe the client's current mental health situation, please include any diagnosis and relevant medication and how long has it been since last hospitalization? Where and why? Please list any relevant workers on the next page.***

Addictions - ***Please describe the client's addiction situation, please include history of substance use, time since last use, and any medications or therapies being used. Please list any relevant workers on the next page.***

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Financial - ***Please describe the client's financial situation, please include OW, ODSP, or other sources of income or benefits. Please list any relevant workers in the section below.***

_____

_____

_____

_____

_____

_____

Service Provider Contacts

1. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

2. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

3. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

4. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

5. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

6. Name: _____ Relation: _____Organization: _____

Telephone no.: _____ Ext No..: _____

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Consent to Collect, Use and Share Personal Health Information

SLPP respects your privacy. The confidentiality of your Personal Health Information is maintained through the application of strict policies and procedures that are consistent with the requirements of current legislation.

SLPP is constantly working to provide you with services that meet your needs. In doing so, we may need to collect, use, or share your data with other health and social service providers, who need to review the assessment data in order to provide services to you.

You have the right to withhold or withdraw your consent to share your personal health information at any time.

Applicant

By checking the boxes below, you agree to what is set out in the following statements:

☐ I consent for SLPP to collect, use, and share information with other health, and social service providers for the purpose of providing quality services and programming.

☐ I confirm that I have read and understand this form and consent to the collection, use and disclosure of personal information as described in the form.

Date: _____(i.e. Jan 9, 2021)

Client Signature: _____

Substitute Decision Maker (SDM) (IF applicable)

If the person filling out this form is an SDM for the applicant, then the questions in this form relate to information about the individual needing support (applicant). If you are the SDM for the applicant, please provide the following information:

Name_____
Address_____
Phone Number _____
Email Address _____
Relationship to Applicant_____
Type of SDM _____

The SDM hereby declares that he or she is the person authorized under the Personal Health Information Protection Act, 2004 to consent to the collection, use and disclosure of personal health information about the applicant and consents on behalf of the applicant.

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