

MHA HOUSING ASSESSMENT V3

Name:		PARIS ID:
DOB:	Age:	PHN:
Gender:		Phone:
Home Address:		

Assessment Start Date: _____ **Assessment End Date:** _____

Reason For Assessment: _____ **Carried Out By:** _____

Band Number, Ethnicity, Current Living Situation

Band Number _____ Ethnicity _____

Current Living Situation

Household _____ Residential Hx _____

House Type _____

Languages & Communication

Language Type	Method	Fluency	Status	Level of Understanding	Main Language	Interpreter
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Client Referred For (For Coastal Use Only)

- | | |
|--|---|
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Consultation Only |
| <input type="checkbox"/> Supported Apartment | <input type="checkbox"/> Subsidy Only (SIL) |
| <input type="checkbox"/> Concurrent Short Term Residential | |

Housing History

Current (Length, Location, Type of Housing)

Past Year

Moves/Evictions

History Of Behavioural Issues

Shelters

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Housing History (continued)

Residential

Supported Apartment

Previous/Current
Subsidies

Other facilities applied
for, Waitlist Date

History of Homelessness

Personal History

1. Cultural / Religious Association
Comments (i.e. Important Cultural Celebrations)

2. Educational / Vocational History
Comments

3. Legal Status (Extended Leave, Past and Present Criminal Charges, Convictions, Legal History)

Unregistered Contacts

Contact Name	Primary Number	Alternate Number	Association	Comments
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External Agencies / Other Professionals

Organization	Relationship	Contact	Telephone	Valid From	Valid To
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Risk Factors

1. Potential for Aggression or Violence

2. Self Harm

3. Substance Use/Abuse: Methods of use, frequency, last use, blackouts, other negative impacts, withdrawal, treatment history and periods of abstinence

4. Triggers to Relapse, Signs of Relapse

5. Victimization and Vulnerability

6. Fire Risk: Smokes indoors, smokes in bed, unsafe kitchen practice

Periods in Hospitals/Clinics

From	To	Hospital/ Clinic	Status	Reason	Notes
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Allergies - Current

Content may have been entered/updated after assessment completed.

Date Entered	Allergen	Category	Source	Reaction	Reaction Details
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Clinical Profile (Medical And Psychiatric)

1. Baseline: i.e. Medical and Psychiatric Problems

2. Signs of Decompensation; Possible Precipitants; History of Rapid Decompensation

3. Coping Mechanisms: Strategies to maintain wellness, handle stressors, etc.

Support Needs/Resources Used

Support Worker /
Housing Worker / Case
Manager

Clubhouse / Gathering
House / Drop-Ins /
Team / Rehab Group

Work / School /
Volunteer

Family Supports / Pets

Life Skills

	Independent	Comments / Support Requirements
1. Manages Mental Illness / Insight	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Life Skills (continued)

	Independent		Comments / Support Requirements
2. Manages Medical Illness / Insight	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Manages Personal Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Social Behaviour / Social Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Maintains Meaningful Activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Maintains a Healthy Diet (List any dietary requests)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Manages Housecleaning Tasks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Manages Own Laundry	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Manages Own Finances	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Uses Public Transportation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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Life Skills (continued)

	Independent		
11. Manages Medications i.e. Medication compliance, frequency of non-compliance, dosage change, client forgetful	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
12. Manages Methadone Maintenance Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
13. Manages Long Acting Injectable Medication (Note Frequency)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
14. Manages Blood Testing (Note Frequency)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Summary/Recovery Plan

Comments relevant to client's placement

Housing Goals

- | | |
|--|--|
| <input type="checkbox"/> Avoid Hospitalization/Institutionalization | <input type="checkbox"/> Stabilize/Improve social relations |
| <input type="checkbox"/> Community Reintegration/Involvement | <input type="checkbox"/> Reduce impact of psychiatric symptoms |
| <input type="checkbox"/> Education and training | <input type="checkbox"/> Manage health conditions |
| <input type="checkbox"/> Employment or volunteering | <input type="checkbox"/> Reduce harm associated with use of drugs/alcohol |
| <input type="checkbox"/> Improvement in ADL functioning (basic self-care) | <input type="checkbox"/> Abstinence |
| <input type="checkbox"/> Improve IADL functioning (more complex activities, e.g. money management) | <input type="checkbox"/> Improve coping skills (e.g. reduce anxiety; strengthen impulse control) |
| <input type="checkbox"/> Avoid illegal activities | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medication Compliance | |

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Recommendations (For Housing Staff Use Only)

- | | | |
|--|---|--|
| <input type="checkbox"/> 24 Hour Staffed Home | <input type="checkbox"/> Group Home | <input type="checkbox"/> Staffed Apartment |
| <input type="checkbox"/> BC Housing | <input type="checkbox"/> ESA (Vancouver Only) | <input type="checkbox"/> SIL |
| <input type="checkbox"/> SSIL (Vancouver Only) | <input type="checkbox"/> Refer to O.T. | <input type="checkbox"/> Other |
| <input type="checkbox"/> Housing Subsidy Only | | |

Comments

Other People Involved

Copies To Be Sent To:

Other Authorizers

Other Authorizer: _____ Date: _____

Other Authorizer: _____ Date: _____

Authorization Details

Carried Out By: _____ Date: _____

Closing Authorizer: _____ Date: _____

Notes:

For Housing Placement

I hereby apply for the benefits for which I may be eligible under the Mental Health Services Program and certify that the information I have provided is correct to the best of my knowledge, and may be released to appropriate Mental Health Service Providers to the Mental health Division, and to

(Name of Person)

Client or Authorized Signature

Date Signed

Case Manager

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- **End of Report** -----