VHA Home HealthCare
Creating More Independence

Durham HOME Program Referral Form

Homelessness Outreach Maintenance and Education for Extreme Clutter and Hoarding

The Durham HOME Program provides services to vulnerable, low-income residents who require housing support/stabilization due to extreme clutter and/or unsanitary living conditions. For more information, please contact the Regional Intake Coordinator 1-888-314-6622 ext. 4192.

- Please fax the **completed referral form** and the attached **signed consent form** to our designated Community Support Fax Number **416-482-8785**

- The determination of acceptance to service is a two-step process:
  - ✓ This completed referral form will be assessed to determine that the client meets program eligibility.
  - ✓ If eligible, an in-home assessment will be scheduled by the HOME Facilitator to assess the condition of the unit, determine client readiness, and create a service plan.

Please note: There may be a wait list for services.

Please indicate which of the following services are being requested
(Please select only one option)

☐ Extreme Clean Durham

☐ Durham Hoarding Support Services

Referral Source Information	
Organization Name:	
City:	
Contact Person Name:	Title:
Work Phone Number:	Work Cell Phone Number:
Email Address:	Fax Number:

Client Information	
First Name:	Last Name:
Street Address: City: Postal Code: Major Intersection:	
Phone Number (Home):	Phone Number (Cell):
Email Address:	Date of Birth (DD/MM/YR):
List household members (relationship and age) and any pets in the home: 1._____ 2._____ 3._____ 4._____ 5._____ 6._____	Any special instructions if client does not have a phone:

Household Information			
Type of Residence	☐Bachelor ☐1 Bedrm ☐2 Bedrm ☐3 Bedrm ☐House #Bedrms _____ ☐Townhouse ☐Other _____		
Unit Conditions	☐Squalor/Unsanitary ☐Clutter/Hoarding		
Infestations	☐Roaches ☐Bedbugs ☐Mice	☐Sharps Specify:	
Smoker ☐Y ☐N	Pets: ☐Y ☐N	No. of Dogs: No. of Cats: Other Pets:	
Spoken Language:		Second Language:	

*DUE TO PRIVACY LAWS WE CANNOT NAME OR OTHERWISE IDENTIFY CLIENTS IN EMAIL COMMUNICATIONS. THEREFORE ANY COMMUNICATIONS BY EMAIL FROM DURHAM HOME WILL IDENTIFY CLIENT BY AN ASSIGNED CLIENT NUMBER.

For Extreme Clean Durham referrals, please review and complete Appendix A

For Durham Hoarding Support Services referrals, please review and complete Appendix B

Appendix A

EXTREME CLEAN PROGRAM CRITERIA

Please check to confirm all criteria is met.

The individual I am referring is:

☐ Living in Durham Region

☐ Over the age of 18

☐ Consenting to this referral (Please see attached consent form)

☐ At risk of eviction/institutionalization due to unsanitary living conditions

☐ Warning Letter from a landlord (submit with referral form)

☐ Living in the home and wishes to retain housing

☐Assets must not exceed $50,000 for single person or $75,000 for family

☐ Meets low-income criteria. Please check which applies:

Household Size	Annual Household Income
☐ 1 Bedroom/Bachelor	$48,000 or less
☐ 2 Bedroom Unit	$54,000 or less
☐ 3 Bedroom Unit	$60,000 or less
☐ 4 or 5 Bedroom Unit	$74,500 or less

Presenting Needs: Brief description of unit condition and need for service

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Laundry Required ☐Y ☐N

Infestation pre-post preparation ☐Y ☐N

Client in hospital? ☐Y ☐N If Yes, **Extreme Cleaning Consent Waiver Form must be signed and faxed by client or POA.**

Extreme Cleaning Consent and Waiver

Date: _____

VHA Home HealthCare has been asked to assist in cleaning your home and sorting the items in your home, including disposing of some items with your agreement, in order to prevent loss of your housing. VHA staff are well-trained cleaners. We will work with you when we can. We will take reasonable precautions to prevent damage to your home and your possessions.

However, due to the current conditions in your home, e.g., extensive clutter, hidden hazards and unsanitary elements, VHA cleaning staff may have to do some of their cleaning and decluttering work when you are not in your home, and there is always some risk of damage during the cleaning process.

Therefore, we need your consent to the following:

☐ If necessary, VHA Home HealthCare staff may enter my home when I am not present in order to provide the cleaning service described above;

☐ VHA Home HealthCare staff may access my home with help from my superintendent, caseworker and/or caregiver in my absence for the purpose of providing the extreme cleaning service;

☐ VHA Home HealthCare cleaning staff may continue to work in my apartment on their own if and when I need to leave my home for any length of time;

☐ VHA Home HealthCare staff may communicate with referral source(s) and/or other service providers involved in providing services or care to me, including but not limited to:
_____.

☒ I absolve VHA Home HealthCare and their cleaning staff of any liability for inadvertent damage to items in my home or the inadvertent discarding of items during the cleaning process.

I have read (or have had someone read to me) and understood the conditions stated above. I have had an opportunity to have my questions answered. I agree to the conditions that have been checked above.

_____ _____
Client Signature/POA Date Date

_____ _____
Witness Date

Appendix B

HOARDING SUPPORT PROGRAM CRITERIA

Please check to confirm all criteria is met.

The individual I am referring is:

☐ Living in Durham Region

☐ Over the age of 18

☐ Consenting to this referral (Please see attached consent form)

☐ At risk of eviction/institutionalization due to extreme clutter

☐ Warning Letter from a landlord (submit with referral form)

☐ Living in the home and wishes to retain housing

☐ Physically and mentally prepared to engage in hoarding support program

☐ Willing to let go of items and ready to do the work

☐ Not at imminent risk of eviction (four-month program)

☐Assets must not exceed $50,000 for single person or $75,000 for family

☐ Meets low-income criteria. Please check which applies:

Household Size	Annual Household Income
☐ 1 Bedroom/Bachelor	$48,000 or less
☐ 2 Bedroom Unit	$54,000 or less
☐ 3 Bedroom Unit	$60,000 or less
☐ 4 or 5 Bedroom Unit	$74,500 or less

IF CLIENT MEETS ALL ABOVE CRITERIA, PLEASE CONTINUE TO THE NEXT SECTION.

Due to the amount of items in each room, how limited is the use of that room?	
Living Room ☐ No interference ☐ Some interference ☐ Moderate interference ☐ Complete interference	**Kitchen** ☐ No interference ☐ Some interference ☐ Moderate interference ☐ Complete interference
Bathroom ☐ No interference	**Bedroom** ☐ No interference

☐ Some interference ☐ Moderate interference ☐ Complete interference	☐ Some interference ☐ Moderate interference ☐ Complete interference
Hallway ☐ No interference ☐ Some interference ☐ Moderate interference ☐ Complete interference	**Other _____** ☐ No interference ☐ Some interference ☐ Moderate interference ☐ Complete interference

Ask the following questions to determine if the individual has hoarding tendencies	**Yes**	**No**
Do you have trouble discarding (or recycling, selling, giving away) things that most other people would get rid of?		
Because of the clutter or number of possessions, is it difficult to use your living spaces and surfaces in your home?		
Do you buy items or acquire free things that you do not need or have enough space for?		
Does your hoarding, saving, acquisitions, and clutter affect your daily functioning?		
Does your hoarding symptom interfere with school, work, or your social and/or family life?		
Are you motivated and willing to have a worker come to your home and are you ready to work alongside the worker to actively reduce the clutter in your living space?		

Is there any other information which you think would be helpful for us to know? (Ex. medical diagnoses, physical limitations, personal information, current supports in place, etc.)

PLEASE CHECK:

☐ **CONSENT FORM IS FAXED WITH COMPLETED REFERRAL FORM (FAX# 416-482-8785)**

Referral Signature: _____ Date: _____

For office use only
Date of Birth:
Client number:

CONSENT FOR THE DISCLOSURE OF PERSONAL HEALTH INFORMATION FOR
DURHAM HOARDING SUPPORT SERVICES (DHSS)

1. I have reviewed and understand the DHSS *Statement of Information Handling Practices*.

2. I have had all my questions answered to my satisfaction.

3. I understand that the following providers will collect, use and disclose my personal health information among each other for the sole purpose of my participation in the Durham Hoarding Support Services Program:

☑ *Region of Durham (program funder)*
☑ *VHA Home HealthCare*
☐ _____
☐ _____
☐ _____

4. I understand that I can withdraw my consent to the collection, use or disclosure of my personal health information by the Providers at any time and my withdrawal of consent will not have any retroactive effect.

HAVING REVIEWED AND FULLY UNDERSTOOD THIS CONSENT AND THE DHSS *STATEMENT OF INFORMATION HANDLING PRACTICES*, I consent to the collection, use and disclosure of my personal health information among the Providers to support me and provide me with services.

_____ _____
Printed Client Name Signature

_____ _____
Substitute Decision Maker, if applicable Signature

_____
Date

Statement of Information Handling Practices for Collection, Use and Disclosure of Personal Health Information for the Durham Hoarding Support Services Program

Collection:
We will only collect the information we need to deliver care under the Durham Hoarding Support Services Program and associated services. We will comply with the regulations and legal requirements governing health information and privacy.

We collect personal health information primarily from you, your substitute decision-maker or others, for the purpose of providing you with appropriate health care. This information may be stored on a secure electronic database.
We may collect the information from other health care professionals who are or who have been involved in your care or treatment only if:

- you provide us with your consent to collect the information from them;
- in the case of an emergency; or
- if we are authorized to do so by legislation.

Use:
We will use your personal health information to:

- Provide health care service to you; and
- Plan and enhance our services to you, including:
  - Evaluation and monitoring of our programs;
  - Chart reviews;
  - Educating our staff to provide health care;
  - Contacting you to gather information on your satisfaction with or concerns about the services you received. This will help us to continuously improve our services to you.

Disclosure:
Your health information will be disclosed in the following limited circumstances:

- With your explicit consent, your personal health information will be shared with other health care professionals involved in the planning and delivery of your care.
- We will disclose personal health information where legislated to do so when:
  - A court order or warrant is provided to us ordering us to disclose your personal health information;
  - If we have reasonable grounds to believe that the disclosure of your personal health information is necessary to eliminate or reduce a significant risk of bodily harm;
  - If we have reasonable grounds to suspect that a child is in need of protection.
- With your explicit consent, we will disclose your information to a third party, such as Ontario Disability Support Program, probation and parole.
- To our funder, the Region of Durham, who require all agency clients of DHSS to sign a consent to disclose personal information for the purpose of the annual file audit by Housing Services staff.

Consent:
When you provide us with personal health information, we believe that you understand that the information may be used and shared with others involved in your care, as noted previously.
You have the right to refuse or withdraw your consent to share all or part of this information at any time. However, this may limit our ability to provide health care to you. If you have questions regarding the collection, use or disclosure of your personal health information, please discuss this with your service provider who will direct your enquiries to the appropriate contact in the participating organization.