

Kenora Emergency Shelter Service Hub Pathway

The Kenora Emergency Shelter Service Hub offers clinical services onsite, provided by CMHA Kenora staff and partners under formal MOUs. Services prioritize individualized client needs to reduce reliance on overnight emergency shelter.

CMHAK REFERRAL

Complete Kenora Emergency Shelter Service Hub referral form

REFERRAL BY ANOTHER AGENCY

Complete referral form:
www.cmhak.on.ca or paper and
fax: 807-468-8590

Once received, agency is
contacted by hub team for
follow-up.

CLINICAL LEAD

Oversees clinical services at Kenora
Emergency Shelter

Coordinates external services
at Kenora Emergency Shelter

Receives referrals for Service Hub
and triage to appropriate service for
internal and external services within
service hub

Client needs assessed using
approved clinical assessment tools
(VI-SPDAT, OCAN,
GAIN-SS, etc.)

Collaborates with partners like
WNHAC for primary care outreach,
RAAM for addictions supports, and
KDSB for housing services.

Provides service navigation to clients
as required

Continuous assessment of
risk related to clients'
housing needs

SERVICES PROVIDED

SERVICE HUB NAVIGATOR

Assertive engagement with patrons of
Kenora Emergency Shelter requiring
connection to services

Works in collaboration with
community partners

Facilitates access to suitable,
affordable housing for identified
population

Client needs assessed using
approved clinical assessment tools
(VI-SPDAT, OCAN,
GAIN-SS, etc.)

Links clients to appropriate services,
supports and resources

Continuous assessment of risk
related to the clients' housing needs

Direct provision of side-by-
side support with clients where
appropriate

Provides service navigation to clients
as required

Involvement is terminated once
individual is housed and wrap-around
services coordinated

Participates in community case
conferencing with partners like
WNHAC and KDSB to promote
primary care and housing via the
By-Name List.

DIVERSION WORKER

Assists with housing options for
patrons staying 14 days overnight in a
given month

Facilitates access to suitable,
affordable housing for
identified population

Works with community partners

Client needs assessed using
approved clinical assessment tools
(VI-SPDAT, OCAN,
GAIN-SS, etc.)

Directly provides side-by-side support
with clients when necessary.

Collaborates and cooperates with
housing providers and landlords

Links clients to suitable services,
supports, and resources

Works with client, case manager and
landlord to develop personalized
service plan

Continuous assessment of risk
related to the clients housing needs

Coordinated wrap-around services as
assessed by client need

Direct provision of
side-by-side support with clients
where appropriate

Involvement is terminated once
individual is housed and wrap-around
supports in place for three months

