Peel Youth Village - Application Form

99 Acorn Place, Mississauga, ON, L4Z 4E2
P – 905-791-5576 F – 905-502-6526

APPLICANT

Last Name	First Name	Date of Birth (M / D / Y)	Sex	Marital Status

Health Card Number	Permanent Resident	Canadian Citizen	Landed Immigrant	Refugee	Sponsored
	☐	☐	☐	☐	☐

Address | Apt/Unit # | City | Postal Code

Preferred Language: ☐ English ☐ French ☐ Other

Applicant Contact Telephone Number(s) &/or Email:

Email:

Home ( ) - Business ( ) - Ext:

Emergency Contact ( ) - Business ( ) - Ext:

Other ( ) - Ext:

Referral Source (Check Off)

☐ Self ☐ Family/Friends ☐ Shelter ☐ Community Case Manager ☐ Education ☐ Crisis ☐ Health Care Org

Name: **Organization:** **Number:** ( ) -

Reason for Referral: ☐ Homeless ☐ Issues at Home ☐ Unemployment ☐ Other ____

Have you previously LIVED at PYV ☐ Yes ☐ No

INCOME

☐ Ontario Works ☐ ODSP ☐ Student Loan ☐ CAS

☐ Part time employment ☐ Full time employment ☐ No Income ☐ Other (specify) _____

EDUCATION HISTORY / GOALS

☐ Currently in school: PT / FT
☐ Some Elementary / Junior High School
☐ Some Secondary / High School
☐ Some College / University
☐ No Formal Schooling
☐ Elementary / Junior High School
☐ Secondary / High School
☐ Night School
☐ College / University
☐ Other: _____

Any concerns about reading abilities or learning? ☐ Yes ☐ No Please explain: _____

List education goals, if any:

1. _____ 2. _____ 3. _____

EMPLOYMENT HISTORY / GOALS

Currently Working? PT / FT Please explain:

Employers Name: _____

Days of Work: ☐ M ☐ T ☐ W ☐ R ☐ F ☐ S ☐ Su Hours of Work: _____

List employment goals, if any:

1. _____ 2. _____ 3. _____

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HOUSING

CURRENT LIVING SITUATION

- ☐ Shelter
- ☐ Living with family or friend but would like to live independently
- ☐ Incarcerated
- ☐ At risk of losing housing
- ☐ Renting with no risk of losing housing
- ☐ No Fixed Address
- ☐ Own Home
- ☐ Evicted from housing

JUSTICE SYSTEM INVOLVEMENT

***Please note:* the following information will *not* be used against you in your application. This information will help to determine what supports will best meet your needs**

- ☐ No Legal Involvement
- ☐ Stay of Proceedings
- ☐ Court Diversion
- ☐ On Bail-Awaiting Trial
- ☐ Awaiting Sentence
- ☐ Incarcerated
- ☐ Unfit to Stand Trial
- ☐ Restraining Order
- ☐ CTO
- ☐ Charges withdrawn
- ☐ Peace Bond
- ☐ Conditional Discharge
- ☐ Time Served
- ☐ Custodial Sentence
- ☐ Probation
- ☐ Ontario Review Board
- ☐ Other: _____

Name of Parole/Probation Officer:	**Organization**	**Number:** ( ) -
Name of Court Diversion Worker:	**Organization**	**Number:** ( ) -

SUBSTANCE USE

Do you use substances? ☐ Yes ☐ No

If yes, what is your substance of choice? _____

HEALTH HISTORY

History of:

- ☐ **Physical Health Concerns:** Diagnosis _____
- ☐ **Mental Health Concerns:** Diagnosis _____
- ☐ **Allergies:** List _____

Suicide attempt in the past 2 years ☐ Yes ☐ No If yes, date of last attempt: _____

Self-Harm behaviour in the past 2 years ☐ Yes ☐ No If yes, date of last incident: _____

Issue with Aggression or Anger Management ☐ Yes ☐ No Explain: _____

Recent Mental Health hospitalization ☐ Yes ☐ No If yes, how many in past 2 years: _____

Where was the last Hospital Admission? _____

Medication Compliant ☐ Yes ☐ No

PROGRAMMING INTERESTS

Workshops are an integral part of the program. Check all of the programs that may interest you:

- ☐ Communication
- ☐ Budgeting
- ☐ Employment
- ☐ Goal Setting
- ☐ Job Skills
- ☐ Housing
- ☐ Laundry
- ☐ Cleaning
- ☐ Time Management
- ☐ Cooking
- ☐ Conflict Resolution
- ☐ Healthy Relationships
- ☐ Social
- ☐ Recreational
- ☐ Fitness
- ☐ Volunteering
- ☐ Tenant Association
- ☐ Other – Please list:

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Declaration of the Applicant
To the best of my knowledge I have provided accurate information in support of my application for Transitional Housing.

x _____ _____
Applicant's Signature *Month* *Day* *Year*

x _____ _____
Guardian / Trustee Signature (If applicable) *Month* *Day* *Year*

( ) _____ _____ _____
Guardian / Trustee Signature (If applicable) *Address* *City* *Postal Code*
Phone Number

Applications submitted should be completed in full and returned to:

SHIP - Peel Youth Village
Attention: Intake
99 Acorn Place
Mississauga, ON L4Z 4E2

Fax: 905-502-6526

CHECKLIST: Did you include the following with your Application?

☐ **Consent to Disclose Personal Health Information -- MUST BE ORIGINALS -- (signed and dated).** ***(Supports -- Doctor, case manager, family member who are permitted to discuss applicant's information for the sole purpose of application for Transitional Housing)***

☐ **Copy of Citizenship, Landed Immigrant status, birth certificate, permanent resident, if applicable**

☐ **Copy of CPIC, Probation/Parole Order, if applicable**

As the program at Peel Youth Village is a Region of Peel program, the applicant's personal information is subject to the Municipal Freedom of Information and Protection of Privacy Act. The information is collected under the authority of the Ontario Works Act 1997, s. 7. The information collected will be used for assessing applications and determining eligibility of applicants for temporary residency at Peel Youth Village as well as to assist SHIP and The Regional Municipality of Peel with the proper operation of the Peel Youth Village program and the provision of applicable program support services to its residents. Additionally information collected will be used for statistical reporting to other government agencies. Any questions regarding this collection may be directed to SHIPs Privacy Officer at 905-795-8742 who can answer questions about the collection of information under this program.

Important Note
It is the policy of SHIP to fully respect each applicant's confidentiality. However, there are limitations on our ability or obligations to maintain confidentiality; SHIP is required to share information when your behaviour poses a threat of physical harm to yourself or someone else, or other legally required reporting situations.

Updated: December 2012, January 2013, February 2013, November 2014, December 2015

Region of Peel
Working for you

PEEL YOUTH VILLAGE

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Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Completed by: □ Client
□ SDM*

I, _____**, authorize** _____
(Print name of client or SDM) *(Print name of organization e.g., doctor, psychiatrist, hospital)*

to disclose my/the personal health information consisting of: _____

_____
(Describe in as much detail as possible the personal health information to be disclosed)

Print the contact information of the person/organization requiring the information:

Name: _____

Position: _____

Organization: _____

Address: _____

_____

_____

I understand that the purpose of disclosing my personal health information to the person or organization noted above is to assist in providing me with health care. I understand that I can refuse to sign this consent form or later withdraw my consent.

Name: _____ Signature: _____

Date of Birth: _____
(MM/DD/YYYY)

Date: _____

Witness Name: _____ Signature: _____

Date: _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

Consent to the Collection, Use and Disclosure of Personal Health Information Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

SHIP is seeking your consent for it to collect, use and/or disclose your personal health information.

Personal health information (PHI) is the information that health care providers (e.g., doctors, hospitals, etc.) collect about you and use to provide you with health care. PHI includes information about:

- your physical health and mental health;
- your health history;
- your family health history;
- the health care you have received;
- your health card number; and
- name of your substitute decision-maker.

What is "collection, use or disclosure" under PHIPA?

"Collection" occurs when SHIP obtains PHI about you in any form (eg. verbal or written) and from any source including family and friends for the purposes outlined in the consent form.

"Use" refers to SHIP using the PHI they have regarding you. For instance, information in your record may be used to develop a Service/Care Plan for you.

"Disclosure" occurs when the information in the possession of SHIP is shared with another health information custodian or a non-health information custodian. For example, SHIP may disclose information to a community program you will be attending.

SHIP will only collect, use and disclose your personal health information with your consent unless a particular collection, use or disclosure is permitted or required by law without your consent.

You can refuse to sign this consent form or withdraw your consent at any time by writing to:

Privacy Officer
Supportive Housing In Peel
107 – 969 Derry Road East,
Mississauga, Ontario
L5T 2J7