

**Supportive Housing and Services – Application Form**

**Applying to the following programs/services:**

Supportive Housing

Peel Youth Village (transitional housing, youth aged 16-24)

Indwell – Lakeshore Lofts

Community Homes for Opportunity (CHO)

Assertive Community Treatment Team (ACTT)

Case Management - Dufferin

Early Psychosis Intervention (EPI, youth ages 14-35, first onset of psychosis)

Hoarding Services

Integrated Seniors Team

Trauma Services

Unsure of program

**Contact Information:**

|  |  |
| --- | --- |
| First Name: | Click or tap here to enter text. |
| Last Name: | Click or tap here to enter text. |
| Preferred Name: | Click or tap here to enter text. |
| Street Address: | Click or tap here to enter text. |
| Apartment Number: | Click or tap here to enter text. |
| City: | Click or tap here to enter text. |
| Province: | Click or tap here to enter text. |
| Postal Code: | Click or tap here to enter text. |
| Telephone Number: | Click or tap here to enter text. |
| Alternative Telephone Number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |

**Alternative Contact Information:**

|  |  |
| --- | --- |
| Name: | Click or tap here to enter text. |
| Telephone Number: | Click or tap here to enter text. Extension: Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Relationship: | Click or tap here to enter text. |
| Organization: | Click or tap here to enter text. |
| Can a message or email be left at the number or address provided? | Yes  No |
| City: | Click or tap here to enter text. |

**More Information About You:**

|  |  |
| --- | --- |
| Date of Birth: | Click or tap here to enter text. |
| Gender: | Click or tap here to enter text. |
| Preferred Pronouns: | She/Her/Hers  He/Him/His  They/Them/Theirs  Unsure  Prefer to not disclose  Not listed  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have an Ontario Health Card? | Yes  No  Unsure |
| Health Card Number: | Click or tap here to enter text. |
| Do you speak English? | Yes  No |
| What is your preferred language? | Click or tap here to enter text. |
| Do you need an Interpreter? | Yes  No |
| What is your ethnicity and/or culture? | Click or tap here to enter text. |
| Do you identify as Indigenous/Aboriginal? | Yes  No  Unsure |
| Immigration Status: | Click or tap here to enter text. |
| What year did you arrive in Canada? | Click or tap here to enter text. |
| What is your primary source of income? | Click or tap here to enter text. |
| What is your secondary source of income? | Click or tap here to enter text. |
| Please enter your total monthly income | $Click or tap here to enter text. |
| Please enter the total value of your assets (this includes RRSPs, TFSAs, etc.) | $Click or tap here to enter text. |

**Housing Information:**

|  |  |
| --- | --- |
| Are you currently homeless: | Yes  No |
| Are you currently at risk of becoming homeless or marginally housed? | Yes  No |
| Who do you presently live with? | Click or tap here to enter text. |
| What type of housing do you presently live in? | Click or tap here to enter text. |
| If no fixed address, please provide a possible location of where you can be found: | Click or tap here to enter text. |

**Health Information – Mental Health:**

|  |  |
| --- | --- |
| Is this your first experience with mental illness? | Yes  No  Unknown |
| How long have you been experiencing mental health difficulties (in years)? | Click or tap here to enter text. |
| Have you been formally diagnosed with a mental illness? | Yes  No  Unknown |
| If yes, what is/was the primary diagnosis: | Click or tap here to enter text. |
| Secondary diagnosis? | Click or tap here to enter text. |
| Additional diagnosis? | Click or tap here to enter text. |
| If you are struggling with any other mental health issue, please explain/state: | Click or tap here to enter text. |
| Have you been to hospital (emergency room visits and/or in-patient stays) due to mental health issues in the last two years? | Yes  No  Unknown |
| Please provide an estimate of the total number of days that you have spent in hospital in-patient units, due to mental health issues, within the past two years (estimate in days): | Click or tap here to enter text. |
| Please list the hospital you have been in and the dates of your visit: | Click or tap here to enter text. |
| Are you currently in the hospital due to mental health issues? | Yes  No |
| Are you currently on a Community Treatment Order (CTO)? | Yes  No |

**Health Information – Other Illness/Disability:**

|  |  |
| --- | --- |
| Do you have any other illnesses/disability? | |
| Concurrent Disorders (substance use and mental illness)? | Yes  No  Unknown |
| Dual Diagnosis (developmental disability and mental illness)? | Yes  No  Unknown |
| Other illness that impacts your day-to-day living? | Yes  No  Unknown |
| If YES to any of the above, please describe: | Click or tap here to enter text. |

**Medical Contacts:**

|  |  |
| --- | --- |
| Do you have a Psychiatrist? | Yes  No |
| If YES, please provide their contact information: | |
| Psychiatrist’s Name: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Telephone Number: | Click or tap here to enter text. |
| Fax Number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Do you have a Physician (i.e., GP, Family Doctor, Walk-In Doctor)? | Yes  No |
| If YES, please provide their contact information: | |
| Psychiatrist’s Name: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Telephone Number: | Click or tap here to enter text. |
| Fax Number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |

**Current Supports:**

|  |  |
| --- | --- |
| Are you currently working with any other service providers? | Yes  No |
| If yes, please provide the following information on each service provider with whom you are **currently** working: | |
| Agency Name: | Click or tap here to enter text. |
| Contact Name: | Click or tap here to enter text. |
| Services Received: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Agency Name: | Click or tap here to enter text. |
| Contact Name: | Click or tap here to enter text. |
| Services Received: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Please describe the informal supports (e.g., family, friend, faith community, cultural groups/community, other community supports) in your life: | Click or tap here to enter text. |

**Safety Risks:**

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| --- | --- | --- | --- | --- |
| We ask the following questions to determine if there are any safety or risk issues of which we should be aware. We know these are sensitive questions and we appreciate you answering them. If you have any recent (i.e., **past two years**) history of the following, please comment (e.g., when, how many incidents, how severe, outcome).  If you struggle with any of the items listed, please indicate how long it has been since the last incident: | | | | |
| Thoughts of suicide | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Suicide attempts | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Self harm behaviour | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Substance use resulting in harm to you | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Lack of attention while smoking | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Mishandling fire/fire setting | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Issues with aggression | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Problems with anger management | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Inappropriate sexual behaviour | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Destroying/abuse of property | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Gambling | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Issues with collecting things | No | 6 months | 6 months – 1 year | 1 – 5 years |
| History of homelessness/risk of homelessness | No | 6 months | 6 months – 1 year | 1 – 5 years |
| Comments or other challenges: | Click or tap here to enter text. | | | |

**Legal Involvement:**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently or in the past been involved with the criminal justice system? | | Yes  No | |
| If yes, please state the number of contacts with the justice system in the previous year: | | Click or tap here to enter text. | |
| Please complete the following if you have legal involvement (check all that apply): | | | |
| Pre-Charge | | Pre-Charge Diversion  Court Diversion Program | |
| Pre-Trial | | Awaiting fitness assessment  In community on own recognizance  Awaiting trial (with or without bail)  Unfit to stand trial  Awaiting criminal responsibility assessment (NCR) | |
| Custody Status | | Ontario (ORB) detained – community access  On probation  ORB conditional discharge  Incarcerated  On parole | |
| Outcomes | | Charges withdrawn  Conditional sentence  Stay of proceedings  Restraining order  Awaiting sentence  Peace bond  NCR  Suspended sentence  Conditional discharge | |
| Other | | No legal involvement  Other criminal/legal problems  Unknown | |
| Please list all current and previous charges: | | | |
| Charge | Date of Charge | | Current Status (on probation, etc) |
| Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. |
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**Housing Details:**

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| Current Living Situation | Hospital  No fixed address  Shelter  Own home  At risk of losing housing  Living with family or friend but would like to live independently  Renting with no risk of losing housing | | | | |
| Housing preferences:  *(Housing locations chosen must be within the region of your supports [family, doctor, etc])* | | | | | |
| Independent Living | Mississauga  Brampton  Malton  Etobicoke/York  Caledon/Bolton  Orangeville | | | | |
| Transitional Housing | Peace Ranch Farm *(located in Caledon, 8 residents, MUST have a diagnosis of Schizophrenia)*  Townhomes *(located in Brampton, shared accommodation, 3-4 residents)*  Recovery Residence – Mississauga *(8 residents, 8-12 hours of support)*  Recovery Residence – Brampton *(8 residents, 8-12 hours of support)*  Peel Youth Village *(Youth aged 16-24 years old, located in Mississauga)* | | | | |
| Do you require a wheelchair accessible unit? | Yes  No | | | | |
| Will anyone else be living with you? | Yes  No | | | | |
| If YES, please provide the following information about who will be living with you: | | | | | |
| Name | | Relationship to You | Date of Birth | Gender | Monthly Income |
| Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**Consent to Collect, Use and Share Personal Health Information**

SHIP 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.

SHIP is constantly working to provide you with healthcare services that meet your needs. In doing so, we may need to collect, use, or share your data with other health 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.

SHIP provides supportive housing for individuals in the Region of Peel, County of Dufferin and West Toronto. Applicants applying for supportive housing must be willing to accept some level of support from a partner organization. The partners include Reconnect, Indwell, INDUS, CMHA – Peel/Dufferin, Trillium Health Partners, PCHS, PAARC, Kerry’s Place, BCCL, Family Transition Place, Our Place Peel, The Salvation Army, John Howard Society and the Region of Peel.

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

I consent for SHIP to collect, use, and share information with the supportive housing partners list above. (For supported housing applicants only.)

I consent for SHIP to collect, use, and share information within regional or provincial systems including but not limited to IAR, HPG, DATIS, Connecting Ontario HTI etc.

I consent for SHIP to collect, use, and share information, including assessments such as HealthLinks SPDAT, OCAN, InterRAI, GAIN Staged Screening and Assessment, hospital records and other external health records, on an as-needed basis for the purpose of intake, assessment, and ongoing health services.

I consent for SHIP to further determine my telephone number, location or continuing interest in service through the contact persons I designate. Please only supply the names of family, friends or workers that you wish us to call.

I understand that if I do not consent or withdraw my consent, that this may affect my ability to receive services.

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

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**Substitute Decision Maker (SDM):**

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| --- | --- |
| If the person filling out this form is a 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: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Email Address: | Click or tap here to enter text. |
| Relationship to Applicant: | Click or tap here to enter text. |
| Type of SDM: | Click or tap here to enter text. |
| 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. | |

**Referral Source/Worker/Agency – for non self-referrals:**

|  |  |
| --- | --- |
| If the person filling out this form is a SDM or professional support person for the applicant, then the questions in this form (listed above) relate to information about the individual needing support (applicant).  If you are the SDM or professional support person for the applicant, please provide the following information: | |
| Name: | Click or tap here to enter text. |
| Agency: | Click or tap here to enter text. |
| Title: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Cell Number: | Click or tap here to enter text. |
| Fax Number: | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Street Address | Click or tap here to enter text. |
| Apt/Suite | Click or tap here to enter text. |
| City | Click or tap here to enter text. |
| Province | Click or tap here to enter text. |
| Postal Code | Click or tap here to enter text. |
| Relationship | Click or tap here to enter text. |
| Is the applicant aware of this referral? | Yes  No |
| **Referrer’s Declaration** | If a person other than the applicant or SDM is completing this application and making the referral, the referrer must complete the declaration below. Please read it carefully. Please note applications will only be accepted with the consent of the applicant or Substitute Decision Maker if there is one.  To the best of my knowledge, the information contained in this application is correct  I have discussed this application with the applicant, and whenever possible, have completed the application together with the applicant  I have obtained the applicant’s knowledge and voluntary consent to make this referral and to the collection, use and disclosure of PHI as set out in this application. |