Supportive Housing and Services – Application Form

Applying to the following programs/services:

☐ Supportive Housing
☐ Peel Youth Village (transitional housing, youth aged 16-24)
☐ 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)
☐ Addiction Services
☐ Hoarding Services
☐ Integrated Seniors Team
☐ Trauma Services
☐ Unsure of program

Contact Information:

First Name:	
Last Name:	
Preferred Name:	
Street Address:	
Apartment Number:	
City:	
Province:	
Postal Code:	
Telephone Number:	
Alternative Telephone #:	
Email:	

Alternative Contact Information:

Name:	
Telephone Number:	Extension:
Email:	
Relationship:	
Organization:	
Message/email be left at the number or address provided?	☐ Yes ☐ No
City:	

More Information About You:

Date of Birth:	
Gender:	
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:	
Do you speak English?	☐ Yes ☐ No
What is your preferred language?	
Do you need an Interpreter?	☐ Yes ☐ No
What is your ethnicity and/or culture?	
Do you identify as Indigenous/Aboriginal?	☐ Yes ☐ No ☐ Unsure
Immigration Status:	
What year did you arrive in Canada?	
What is your primary source of income?	
What is your secondary source of income?	
Please enter your total monthly income	$
Please enter the total value of your assets (this includes RRSPs, TFSAs, etc.)	$

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?	
What type of housing do you presently live in?	
If no fixed address, please provide a possible location of where you can be found:	

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)?	
Have you been formally diagnosed with a mental illness?	☐ Yes ☐ No ☐ Unknown
If yes, what is/was the primary diagnosis:	
Secondary diagnosis?	
Additional diagnosis?	
If you are struggling with any other mental health issue, please explain/state:	
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):	
Please list the hospital you have been in and the dates of your visit:	
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:	

Medical Contacts:

Do you have a Psychiatrist?	☐ Yes ☐ No
If YES, please provide their contact information:	
Psychiatrist's Name:	
Address:	
Telephone Number:	
Fax Number:	
Email:	
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:	

Address:	
Telephone Number:	
Fax Number:	
Email:	

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:	
Contact Name:	
Services Received:	
Phone Number:	
Email:	
Agency Name:	
Contact Name:	
Services Received:	
Phone Number:	
Email:	
Please describe the informal supports (e.g., family, friend, faith community, cultural groups/community, other community supports) in your life:	

Safety Risks:

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:				

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:	
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)

Housing Details:

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**

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.

Substitute Decision Maker (SDM):

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:	
Address:	
Phone Number:	
Email Address:	
Relationship to Applicant:	
Type of SDM:	
☐ 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:	
Agency:	
Title:	
Phone Number:	
Cell Number:	
Fax Number:	
Email	
Street Address	
Apt/Suite	
City	
Province	
Postal Code	
Relationship	
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.