Supportive Housing and Services – Application Form

The below application is to learn more about you to best support/navigate your application for supportive housing and/or services with SHIP.

Applying to the following programs/services:

Supportive Housing	Services
☐Independent Supportive Housing	☐ Assertive Community Treatment Team (ACTT)
Congregate Living: ☐ Peace Ranch Farm ☐ Peace Ranch Townhomes ☐ Recovery Residences	☐ Case Management Dufferin
☐ Community Homes for Opportunity (CHO)	☐ Early Psychosis Intervention (EPI)
☐ Peel Youth Village (PYV) – youth aged 16 - 24	☐ Hoarding Services
☐ Unsure of Program	☐ Integrated Seniors Team (IST)
	☐ Trauma Services
	☐ Unsure of program

Self-referral ☐

Someone's behalf ☐

If a person other than the applicant is completing this application and making the referral, the applicant must be made aware and provide consent to proceed with the application.

Date referral discussed with client and consent updated: _____

Applicant Contact Information:

Legal First Name:	
Legal Last Name:	
Preferred Name:	
Street Address:	
Apartment Number:	
City:	
Province:	
Postal Code:	
Contact Number:	
Alternative Contact Number:	
Can a message be left at the numbers provided above?	☐ Yes ☐ No
Email:	
Can an email be sent at the address above?	☐ Yes ☐ No

More Information About the Applicant:

Date of Birth:	
Gender:	
Pronouns:	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Unsure ☐ Prefer to not disclose ☐ Not listed ☐ Other: _____
Does the applicant have an Ontario Health Card?	☐ Yes ☐ No ☐ Unsure
Health Card Number:	
Does the applicant speak English?	☐ Yes ☐ No
What is the applicant's preferred language?	
Does the applicant need an Interpreter?	☐ Yes ☐ No
Status in Canada?	☐ Canadian Citizen ☐ Permanent Resident ☐ Refugee/Refugee Claimant
Is the applicant a veteran?	☐ Served in Canadian Armed Forces ☐ Served in Canadian Allied Armed Forces ☐ Served in Armed Forces outside of Canada

Current Housing Information:

Is the applicant currently homeless:	☐ Yes ☐ No
If no fixed address, please provide a possible location of where the applicant can be found:	

Health Information:

Has the applicant been formally diagnosed with a mental illness?	☐ Yes ☐ No ☐ Unknown
If yes, what is/was the primary diagnosis:	
Concerns regarding substance use	☐ Yes ☐ No ☐ Unknown
Neurocognitive (developmental disability, dual diagnosis)?	☐ Yes ☐ No ☐ Unknown

Safety and Legal Involvement:

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 (e.g., **past two years**) history of the following, please complete the below:

Harm to Self	☐ Yes ☐ No ☐ Unknown			
Harm to Others/Physical &/or Verbal Acts of Violence	☐ Yes ☐ No ☐ Unknown			
Concerns with anger management	☐ Yes ☐ No ☐ Unknown			
Mishandling fire/fire setting	☐ Yes ☐ No ☐ Unknown			
Inappropriate sexual behaviour	☐ Yes ☐ No ☐ Unknown			
Destroying/abuse of property	☐ Yes ☐ No ☐ Unknown			
Other risky behaviours	☐ Yes ☐ No ☐ Unknown If yes, details:			
Concerns with collecting things/Hoarding	☐ No	☐ 6 months	☐ 6 months to 1 year	☐ More than 1 year
Is the applicant currently or in the past been involved with the criminal justice system? (Examples: contact with police, court case, probation, parole, etc.)	☐ Yes ☐ No			

Housing Preference:

(Please note that the Central Intake & Access Team will be review your preferences during the intake assessment to determine if we can meet your housing and support request)

Type of housing:	☐ Independent ☐ Transitional Congregate (1-3 years) ☐ Long-term Congregate
City of choice:	☐ Mississauga ☐ Brampton ☐ Malton ☐ Etobicoke/York ☐ Caledon/Bolton ☐ Orangeville ☐ Grandvalley ☐ Shelburne
Do you require a wheelchair and/or an 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**

Alternate Contact Information:

Legal Name:	
Preferred Name:	
Telephone Number:	Extension:
Email:	
Relationship:	
Message/email be left at the number or address provided?	☐ Yes ☐ No
By providing this information, the applicant is giving us permission to contact this person	

Circle of Care:

Are you currently working with any other service providers?	☐ Yes ☐ No
This information is helpful to have to best link/refer the applicant to support services within SHIP and in the community.	
Agency Name:	
Contact Name:	
Services Received:	
Phone Number:	
Email:	
By providing this information, the applicant is giving us permission to contact this person	

Medical Contacts:

Do you have a Psychiatrist?	☐ Yes ☐ No
If YES, please provide their contact information:	
Psychiatrist's Name:	
Telephone Number:	
Do you have a Physician (e.g., GP, Family Doctor, Walk-In Doctor)?	☐ Yes ☐ No
If YES, please provide their contact information:	
Physician's Name:	
Telephone Number:	
By providing this information, the applicant is giving us permission to contact this person	

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, Salesforce, HIFIS, 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):

☐ 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.	
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:	☐ Personal Care ☐ Financial ☐ Other: _____

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

If the person filling out this form is a professional support for the applicant, then the questions in this form (listed above) relate to information about the individual needing support (applicant). If you are a professional support person for the applicant, please provide the following information:	
Name:	
Agency:	
Title:	
Phone Number:	
Email:	
Referrer's Declaration	If a person other than the applicant is completing this application and making the referral, the referrer must complete the declaration below. Please read it carefully and 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 confirmed the applicant's awareness of this application and their voluntary consent to make this referral and to the collection, use and disclosure of PHI as set out in this application.