

COMMUNITY CONNECTIONS: HOUSING & SUPPORT APPLICATION FORM

For Housing complete all sections

For Groups complete sections A and C

Section A			
Last Name	First Name	Middle Name	Date of Birth (dd/mm/yy)
<div style="display: flex; justify-content: space-between;"> <div> Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other </div> <div> Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed </div> <div> Health Card Number & Version </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Address</div> <div>Apt/Unit #</div> <div>City</div> <div>Postal Code</div> </div>			
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other <input type="checkbox"/> Aboriginal <input type="checkbox"/> Non-Aboriginal			
Contact Phone Number(s)			
<div style="display: flex; justify-content: space-between;"> <div>Home</div> <div>() - </div> <div>Altern () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Psychiatrist</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Family Dr. or Nurse Practitioner</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Social Worker/Case Manager</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Addiction Worker</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Substitute Decision Maker</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Public Trustee</div> <div></div> <div>Phone () - </div> </div>			
<div style="display: flex; justify-content: space-between;"> <div>Other</div> <div></div> <div>Phone () - </div> </div>			
Referral Source (check off)			
<input type="checkbox"/> Self <input type="checkbox"/> Mental Health Worker <input type="checkbox"/> Hospital <input type="checkbox"/> Addiction Service <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Doctor			
<div style="display: flex; justify-content: space-between;"> <div>Name:</div> <div>Organization:</div> <div>Phone:</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div></div> <div></div> <div>() - </div> </div>			
Mental Health and/or Addictions Diagnoses: _____			
Other Diagnoses: _____			
Dual Diagnosis (intellectual disability & mental illness) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Substance Use Issues <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Gambling <input type="checkbox"/> Not Applicable			
Suicide Attempt in past 2 years <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last attempt: _____			
Self-Harm behavior in the past 2 years <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last incident: _____			
Recent Mental Health hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many in the past 2 years: _____			
Where was the last hospital admission? _____			
Currently on CTO <input type="checkbox"/> Yes <input type="checkbox"/> No			
Age of Onset of Mental Illness _____ Age of First Psychiatric Hospitalization _____			
Do you have a Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____			
Do you have a Public Trustee <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____			

Highest Level of Education

- | | |
|---|--|
| <input type="checkbox"/> Some Elementary/Junior High School | <input type="checkbox"/> Elementary/Junior High School |
| <input type="checkbox"/> Some Secondary/High School | <input type="checkbox"/> Secondary/High School |
| <input type="checkbox"/> Some College/ University | <input type="checkbox"/> College/University |
| <input type="checkbox"/> No Formal Schooling | |

Current Living Situation

- ☐ Living with Family or Friends but want to live independently
☐ Own Home
☐ Renting with no risk of losing housing
☐ At risk housing
☐ Shelter
☐ Hospital
☐ Incarcerated
☐ No Fixed Address
☐ Other (please describe): _____

What Type of support do you need? Check off the level of support you require and provide comments

- | | | | |
|-----------------------------------|-------------------------------|-------------------------------|--------------------------------|
| Managing medication | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Managing money | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Doing household chores | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Meal preparation/Grocery shopping | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Using transportation | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Using community resources | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Crisis Management | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Managing symptoms of mood | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Managing symptoms of anxiety | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Managing symptoms of psychosis | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |
| Social Recreation support | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot |

GROUP SERVICES OPTIONS

- ☐ Group Services – **Community Connections** ☐ The Green House – **Warton**

SECTION B: HOUSING APPLICATION**Applicant Income**

- | | | | |
|---|---|------------------------------|--|
| <input type="checkbox"/> ODSP | <input type="checkbox"/> Ontario Works | <input type="checkbox"/> CPP | <input type="checkbox"/> OAS |
| <input type="checkbox"/> Retirement Pension | <input type="checkbox"/> Employment Insurance | <input type="checkbox"/> LTD | <input type="checkbox"/> Part Time or Full Time Employment |
| <input type="checkbox"/> No Income | Annual Income _____ | | |

Have you had any Criminal Offenses in the past:

☐ Yes (complete below)

☐ No

☐ Court Diversion

☐ Probation

☐ Awaiting Sentence

☐ Incarcerated

Name of Parole/Probation Officer:

Organization

Phone Number

(____) ____--____

Name of Court Diversion Worker

Organization

Phone Number

(____) ____--____

SUPPORTIVE HOUSING OPTIONS

Housing locations chosen must be within the region of your supports (Doctors, Case Worker, family etc)

Apartment Program – Independent Living**Group Home Living**

- | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Owen Sound | <input type="checkbox"/> Hanover | <input type="checkbox"/> Markdale |
| <input type="checkbox"/> Wiarton | <input type="checkbox"/> Port Elgin | <input type="checkbox"/> Kincardine |
| <input type="checkbox"/> Meaford | <input type="checkbox"/> Other: _____ | |

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Brooke House | <input type="checkbox"/> Frank Street |
|---------------------------------------|---------------------------------------|

Community Homes for Opportunity

- | | | |
|---|--|--|
| <input type="checkbox"/> Kent Residence | <input type="checkbox"/> Meaford Place | <input type="checkbox"/> Hanover Place |
|---|--|--|

Portable Housing Benefit

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Grey County | <input type="checkbox"/> Bruce County |
|--------------------------------------|---------------------------------------|

Current Rent \$_____ . ____ Utilities Included ☐ Yes ☐ No

Landlord _____ Phone (____) ____--____

SECTION C: DECLARATION OF APPLICANT

To the best of my knowledge I have provided accurate information in support of my application.

Applicant's Signature

Date

Advocate/Person Assisting Applicant

Date

SUPPORTING DOCUMENTATION

**** In order to ensure this application can be processed, include all applicable documentation**

- ☐ Completed Consent (initialed, signed and witnessed)
- ☐ Copies of most recent Columbia Scale and GAINS Screener
- ☐ Copies of Community Treatment Orders, Probation Orders etc.

Return completed application form and supporting documentation to:

Community Connections: Housing & Support
1105 1st Avenue East
Owen Sound, Ontario N4K 2E2
Telephone: 519-371-2390 Fax: 519-372-1592

All information must be provided before this application will be processed.
If you require accessibility assistance, please contact our office at the above number
and we will be pleased to assist you.

HopeGreyBruce Mental Health and Addictions Services

CONSENT TO COLLECT AND DISCLOSE PERSONAL HEALTH INFORMATION

HopeGreyBruce Mental Health and Addictions Services operates the following mental health and addiction programs:

- Bruce Mental Health Counselling Service (c/o Central Grey Bruce Community Mental Health Team)
- CHOICES: Drug and Alcohol Counselling for Youth
- Community Connections: Housing and Support
- Community Network Support Team
- Consumer/Survivor Development Project
- Family Support Initiative
- Grey Mental Health Counselling Service (c/o South Grey Community Mental Health Team)
- New Directions for Alcohol, Drug and Gambling Problems

Our organization and its programs are committed to respect and protect the privacy of your personal health information.

I, _____ hereby authorize HopeGreyBruce Mental
(name of client or substitute decision maker – circle one) Health and Addictions Services:

☒ To disclose my personal health information or the personal health information of
_____ to the person/agency listed below:

(name of person for whom I am the substitute decision maker)

Name of Person/Agency: Grey Bruce Health Services

Address: _____

I understand that the information to be disclosed was compiled by the following program(s):

Community Connections: Housing and Support

☒ To collect my personal health information or the personal health information of
_____ from the person/agency listed below:

(name of person for whom I am the substitute decision maker)

Name of Person/Agency: Grey Bruce Health Services

Address: _____

Personal Health Information to Be Shared:

Please place a tick mark and your initials beside the type of information you are authorizing us to share.

- ☒ Initials: _____ All information that is required to provide / coordinate health care
- ☒ Initials: _____ Assessment and Treatment Information
- ☒ Initials: _____ Admission and Discharge Summaries
- ☒ Initials: _____ Progress Notes
- ☒ Initials: _____ Other (specify) All info. req'd. to assess and provide supportive services

I understand the purpose for disclosing /collecting this information. I also understand that I can refuse to sign this consent form and that I can withdraw my consent to this disclosure at any time by providing notice.

My Name: _____ Home Tel: _____ Work Tel.: _____
(please print)

My Address: _____ My date of birth: _____

Relationship to person for whom I am substitute decision-maker: _____

My signature: _____ Date: _____

Signature of Witness _____ Date: _____