



"Rebuilding a life...
Renewing a dream"

SUPPORT FOR INDEPENDENT LIVING PROGRAM APPLICATION

237 Second Street, P.O. Box 832. Midland, ON. L4R 4P4

Phone: 705-526-1305. Fax: 705-526-9248

Name (First/Middle/Last/Alias): _____ Phone#: _____ Alt #: _____

Address: _____

Date of Birth: _____ Marital Status: _____ Ethnicity: _____

Man, Women, I identify as _____

Preferred Language of communication: _____ Language at Birth _____

Health Card #/ _____ Version Code: _____

Aboriginal?: Yes No Citizenship?: _____

Referral Source: _____ Referral's Contact Number: _____

Next of Kin: _____
(Name) (Telephone)

(Address) (Relationship)

Emergency Contact Person: _____
(Name) (Telephone)

(Address) (Relationship)

Case Manager/Therapist: _____
(Name)

(Address) (Telephone)

Family Doctor: _____
(Name)

(Address) (Telephone)

Psychiatrist: _____
(Name)

(Address) (Telephone)

Primary Diagnosis: _____ Secondary Diagnosis: _____

Do you have any medical issues?: Yes No Do you have any chronic illnesses?: Yes No

If answered yes to either of the above please provide details: _____

CURRENTLY DIFFICULTIES:

- Threat to Others
- Threat to self
- Attempted Suicide
- Physical Abuse
- Sexual Abuse
- Educational
- Housing
- Legal
- Medical Problems
- Specific symptoms of Serious Mental Illness
- Social/Interpersonal Problems
- Occupational/Employment/Vocational
- Problems with Relationships
- Problems with Substance Abuse
- Problems with Addictions
- Activities of daily living
- Requiring Substitute Decision Maker for Personal Care/Finances
- Other

If answered yes to any of the above please provide details: _____

CURRENTLY TREATMENT: (LIST MEDICATION, COUNSELLING, SUPPORT GROUPS, ETC): _____

What other community agencies are you involved with?: _____

Do you have a documented crisis plan?: Yes No If yes, where?: _____

Have you completed an OCAN?: Yes No If yes, where?: _____

Are you on a Community Treatment Order (CTO): Yes No

When did you begin experiencing mental health difficulties?: _____

At what age were you when you had your first psychiatric hospitalization?: _____

How many times have you been hospitalized in the past two years?: _____

LIST NAMES & DATES OF LAST 4 PSYCHIATRIC HOSPITAL ADMISSIONS:

<u>Name of Hospital</u>	<u>Admitted on:</u>	<u>Discharged on:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

RATE YOURSELF ON THE FOLLOWING:

	GOOD	FAIR	POOR
1. Budgeting money			
2. Paying rent on time			
3. Cooking			
4. Shopping for groceries			
5. Doing laundry			

WHY DO YOU WANT TO BECOME A CLIENT OF THE SUPPORT FOR INDEPENDENT LIVING PROGRAM?: _____

WHAT ARE YOUR GOALS?: _____

WHAT SKILLS WOULD YOU LIKE HELP LEARNING/STRENGTHENING?:

CHECK THE BOX THAT APPLIES TO YOU:

- | | |
|--|--|
| <input type="checkbox"/> Employed Part Time | <input type="checkbox"/> Student or Retraining |
| <input type="checkbox"/> Employed Full Time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Able to Work but Unemployed | <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> Volunteer Work | <input type="checkbox"/> Self Employed |
| <input type="checkbox"/> Other | |

Have you engaged in paid employment at some time over the past six months?: Yes No

What is the last grade/year of education you have completed? : _____

FINANCES:

Source of Income (Ontario Works, ODSP, CPP, Employment, etc.): _____

Monthly Amount: _____

WHERE ARE YOU PRESENTLY LIVING:

- Private House or Apartment-Market rent
- Rooming House
- Home for Special Care
- Group Home
- Homeless
- Shelter
- Supportive Housing
- Correctional Facility
- Retirement Home
- Unknown
- Private House or Apartment-Subsidized rent
- Long Term Care Facility
- Municipal Non-Profit Housing
- Private Non-Profit Housing
- Psychiatric Hospital
- General Hospital
- Specialty Hospital
- Chronic Care Hospital
- Other _____

WHO DO YOU LIVE WITH?:

- Self
- With parents
- With your children
- With other relatives
- With a spouse/partner
- With a spouse/partner and others
- With non-relatives

Is your current living arrangement satisfactory?: Yes No If not, why?: _____

Have you experienced homelessness at any time over the past six months? Yes No

Have you ever been evicted? Yes No

Information contained in this application will be used to collect data for program and County evaluation purposes. The applicants name will not be used in this collection process. By signing below the applicant consents to the use of this information for this purpose and is aware that they can withdraw their consent at any time. Participating or refusing to participate in the collection of data will not affect services available to the applicant.

May we use this information for evaluation purposes? Yes No

Signature of Applicant: _____ Date: _____

Please forward the completed application to Heather Cusson, Case Management Supervisor, at Wendat Community Programs, 237 Second Street, P.O Box 832, Midland, ON, L4R 4P4. Or fax to 705-526-9248. The Program Supervisor can also be reached by telephone Monday to Friday, 9 AM to 5 PM at 705-526-1305.

OFFICE USE ONLY

Referral Date: _____ Referral Status: _____

Intake Outcome: _____ Service Entry Date: _____