



## Mental Health & Addictions Supportive Housing - Application Form

### *Purpose of the Form*

The Toronto Mental Health and Addictions Supportive Housing Network (Network) has been established to streamline access to supportive housing. With this application form, you can be considered for supportive housing for persons with mental health challenges as well as for persons with problematic substance use offered by the Network Agencies.

### **To apply for supportive housing for persons with mental health challenges, you must:**

- o be challenged with mental health issues
- o be at least 16 years of age
- o require rent geared to income housing

### **To apply for supportive housing for persons with problematic substance use, you must:**

- o have a severe and active substance use challenge
- o be homeless or marginally housed
- o qualify for a housing subsidy under the criteria set by the Ministry of Health
- o be a high intensity service user of ER Departments, Withdrawal Management Systems, Hospitals, and/or the Justice System

**NOTE: to apply for supportive housing for persons with problematic substance use, you must fill out the pre-screen form first, available at [www.TOsupportivehousing.ca](http://www.TOsupportivehousing.ca)**

The questions in this form ask what kind of housing you want, as well as other questions about you that are related to supportive housing, such as your support needs. The funders for this project require us to also collect basic data but this information will be provided in a manner that does not identify you. **The questions that are funder requirements are identified with an \***.

The housing providers have different eligibility criteria, so **it is important to fill out the application form completely and accurately. Also, please PRINT clearly with black or blue ink, so our computer system can read your application form.** The application form is designed to assist us in finding housing that closely matches the information you provide, and the more accurately you fill out the application form, the better this match will be.

Before filling out this application form, we encourage you to visit our website. Our website lists information on all of the supportive housing providers, and will help you make an informed decision about your housing options: [www.TOsupportivehousing.ca](http://www.TOsupportivehousing.ca)

If you need assistance, or have any questions about the application form, please call the Housing Registry Worker at 416-979-1994, ext. 231, or 416-979-1994, ext. 264

**After you complete the application form, please send it to the Toronto Mental Health & Addictions Supportive Housing Network, 15 Toronto Street, 9th Floor, Toronto, ON, M5C 2C5, or fax it to 416-916-1689.**

You will be contacted within five (5) business days of receiving your application to confirm receipt, verify your eligibility for supportive housing, based on the criteria above, and to discuss any availability of vacancies.

### ***Our Privacy Policy***

At Coordinated Access to Supportive Housing, we take your privacy seriously. At all times our aim is to ensure that all personal health information (PHI) is properly collected and protected. We use your PHI to identify your needs for the purpose of providing you housing and support. We store your PHI in a responsible way and we dispose of it in a safe and timely manner when it is no longer required. We meet all legislative requirements with respect to privacy and adhere to the guidelines outlined in the Personal Health Information Protection Act (PHIPA).

We collect, use and disclose your PHI to make referrals for housing placement, to determine the appropriate housing placements, and to fulfill other purposes required or permitted by law. We collect, use and disclose de-identified information about our applicants to plan and deliver services, for program evaluation, for statistical purposes, and for reporting purposes to the funders of CASH.

In order to review your personal health information, or if you have any questions or concerns about your privacy, please contact the Privacy Officer, Amanda Eaton, at 416-979-1994, ext. 261, or [aeaton@loftcs.org](mailto:aeaton@loftcs.org)

FOR INTERNAL PURPOSES ONLY		
	DATE	INITIAL
APPLICATION RECEIVED		

Section 1: APPLICANT INFORMATION

PLEASE PRINT CLEARLY!

First Name:

[Grid for First Name]

Middle Initial:

[Grid for Middle Initial]

Last Name:

[Grid for Last Name]

Street Address:

[Grid for Street Address]

Apt. No:

[Grid for Apt. No.]

City:

[Grid for City]

Province:

[Grid for Province]

Postal Code:

[Grid for Postal Code]

Telephone Number:

[Grid for Telephone Number]

Age\*:

[Grid for Age]

Birthday:

[Grid for Birthday DAY MONTH YEAR]

Gender\*:

[Grid for Gender]

Are you currently in temporary housing or homeless?

[Yes] [No]

Where are you currently living (please check one)\*?

- Approved Homes/Homes for Special Care
Correctional/probation facility
Domiciliary hostel
General hospital
Psychiatric hospital
Other specialty hospital
No fixed address
Hostel/shelter
Municipal non-profit
Other:
Private non-profit housing
Private house/apt. - owned/market rent
Private house/apt. - other/subsidized
Retirement home/senior's residence
Rooming/boardng home
Supportive housing - congregate living
Supportive housing - assisted living (developmental)
Long-term care facility
Unknown

Who are you currently living with (please check one)\*?

- I live by myself
Spouse/partner
Spouse/partner & others
Children
Parents
Other:
Relatives
Non-Relatives

Status in Canada\*: Canadian Citizen Landed Immigrant Refugee Claimant Other

Year of Arrival: Aboriginal Origin\*: Aboriginal Non-Aboriginal Unknown

Do you speak English? Yes No

How well do you communicate in English? Very Well Well Average Poorly

What is your preferred language\*?

[Grid for Preferred Language]

**Section 2: HOUSING PREFERENCES**

PLEASE PRINT CLEARLY!

Are you prepared to live anywhere in the City of Toronto?  Yes  No

If not, please indicate your location preferences (check as many as you like):

- West End of Toronto (Bathurst to Islington, Lawrence to Lakeshore)
- East End of Toronto (Don Valley to Warden, Lawrence to Lakeshore)
- Downtown Core of Toronto (Bathurst to Don Valley, Lawrence to Lakeshore)
- North York (North of Lawrence)
- Etobicoke (West of Islington)
- Scarborough (East of Warden)

There is a limited amount of supportive housing units available for families. Does this apply to you?  Yes  No

If yes, please provide the following information about your family:

Name	Relationship to You	Date of Birth (d/m/y)	Gender	Monthly Income

Do you want to living in housing for (check all that apply):

- Men & Women
- Women Only
- Men Only

Some of the Network agencies have contracts with owners and operators of boarding homes to provide accommodation and meals for tenants. It is often possible to match an applicant to a boarding home more quickly than in other supportive housing.

Would you like to be referred to a boarding home?  Yes  No

Would you share a room with someone you don't know?  Yes  No

What other types of supportive housing will you accept (check all that apply)?

- Rooming House
- Shared Living in a House or Apartment (own bedroom but rest of the house is shared)
- My Own Apartment - Dedicated Building (all tenants are people living with mental health challenges)
- My Own Apartment - Scattered Unit (some tenants are people living with mental health challenges)

Do you require housing suitable for a person with physical ability issues?

- Yes
- No

If yes, please explain:

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Please list any particular agencies (see list below) that you want your application to be considered for (to a total of 5). Agencies should be listed in order of preference (i.e. with your first choice listed as #1, etc.). If there is a particular location you do not want to be considered for, you may indicate that as well, below.

Please note that these are preferences and agencies may screen for support needs, to ensure that you are matched up with the best possible provider. Agencies may have additional eligibility criteria. Please see our website (www.TOsupportivehousing.ca) for descriptions of these criteria to avoid disappointment.

Agency	Major Intersection/Location (optional)
1. <input style="width: 100%; height: 50px;" type="text"/>	
2. <input style="width: 100%; height: 50px;" type="text"/>	
3. <input style="width: 100%; height: 50px;" type="text"/>	
4. <input style="width: 100%; height: 50px;" type="text"/>	
5. <input style="width: 100%; height: 50px;" type="text"/>	

If there is a particular agency that you would prefer NOT to be considered for, please indicate:

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Do you want the Network Office to also submit your application to the agencies that have the supportive housing that most closely matches your needs and preferences, in addition to your housing preferences listed above?  Yes  No

**Housing Providers for Supportive Housing for Persons with Mental Health Challenges:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>Accommodation Information &amp; Support</li> <li>Bayview Community Services</li> <li>Canadian Mental Health Association Toronto</li> <li>Chai Tikvah Foundation</li> <li>Centre for Addiction and Mental Health</li> <li>Community Outreach Services (Toronto East General Hospital)</li> <li>COTA Health</li> <li>Eden Community Homes</li> <li>George Herman House</li> <li>Good Shepherd Non-Profit Homes</li> <li>Habitat Services</li> <li>Hong Fook Mental Health Association</li> <li>House of Compassion</li> <li>Houselink Community Homes</li> </ul> | <ul style="list-style-type: none"> <li>LOFT Community Services</li> <li>Madison Community Services</li> <li>Mainstay Housing</li> <li>Margaret Frazer House</li> <li>Parkdale Activity - Recreation Centre</li> <li>Pilot Place Society</li> <li>Progress Place</li> <li>Regeneration Community Services</li> <li>Rouge Valley Health System</li> <li>St. Jude Community Homes</li> <li>St. Stephen's Community House</li> <li>Street Haven</li> <li>TSH - Manse Road Residential Support Services</li> <li>WoodGreen Community Services</li> <li>YWCA Toronto</li> </ul> |
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**Partners for Supportive Housing for Persons with Problematic Substance Abuse Challenges:**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>Breakaway / Regeneration Community Services</li> <li>Fred Victor Center</li> <li>Good Shepherd Non-Profit Homes</li> </ul> | <ul style="list-style-type: none"> <li>Jean Tweed Centre / Mainstay Housing</li> <li>LOFT Community Services / Fife House</li> <li>Toronto Community Addictions Team (TCAT)</li> </ul> |
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**Section 3: APPLICANT'S PREVIOUS HOUSING REFERENCES AND HISTORY**

Under the *Residential Tenancies Act*, in selecting prospective tenants, landlords may use income information, credit checks, credit references, rental history, guarantees or other similar business practices permitted under the *Human Rights Code* regulations. Please list your housing history for the past three years:

Address: \_\_\_\_\_  
Type of Housing: \_\_\_\_\_  
Landlord/Agency Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Date moved in: \_\_\_\_\_ Date moved out: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Address: \_\_\_\_\_  
Type of Housing: \_\_\_\_\_  
Landlord/Agency Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Date moved in: \_\_\_\_\_ Date moved out: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Address: \_\_\_\_\_  
Type of Housing: \_\_\_\_\_  
Landlord/Agency Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Date moved in: \_\_\_\_\_ Date moved out: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Other comments relating to your housing history:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 4: APPLICANT'S PHYSICAL AND MENTAL HEALTH STATUS**

Do you have any physical health conditions or challenges (ex. allergies, diabetes, hearing impairment), not including any mental health challenges?\*

Yes  No

If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

**MENTAL HEALTH CHALLENGES - please answer if you have been challenged by mental health issues:**

How long have you been challenged by mental health issues (i.e. length of time)?

Approximate number of years: \_\_\_\_\_

Or year of first experience: \_\_\_\_\_

Have you ever been formally given a mental health diagnosis?  Yes  No  Don't Know

If yes, what is/was the primary diagnosis (please select one)\*?

- Adjustment Disorders
- Dissociative Disorders
- Factitious Disorders
- Mood Disorder
- Schizophrenia and Other Psychotic Disorder
- Delirium, Dementia, and Amnestic and Cognitive Disorders
- Unknown
- Other - please state: \_\_\_\_\_
- Anxiety Disorder
- Eating Disorders
- Impulse Control Disorders NOS
- Personality Disorders
- Somatoform Disorders
- Mental Disorders due to General Medical Conditions

If you are struggling with any other mental health issue, please explain/state:

\_\_\_\_\_

**SUBSTANCE USE CHALLENGES - please answer if you have been challenged by substance use:**

If you are struggling with any issues related to substance use (drugs or alcohol), please state/explain\*:

\_\_\_\_\_

How long have you been challenged with substance use issues? \_\_\_\_\_

If you are struggling with any intellectual disability, please explain/state\*:

\_\_\_\_\_

Have you been to a hospital emergency department in the past two (2) years for mental health reasons\*?

Yes  No

If yes, how many times have you needed to use emergency services in the past two years\*? \_\_\_\_\_

Have you been hospitalized due to mental health issues in the past two years\*?

Yes  No

If yes, please provide the following information:

Number of times hospitalized\*: \_\_\_\_\_

Number of hospitalization days\*: \_\_\_\_\_

Section 5: APPLICANT'S STRENGTHS AND RESOURCES

How have you gotten through the tough times in your life?

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What supports have you found useful? What do you wish had happened?

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What have these experiences taught you?

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Are there any positive ways in which you have changed or grown as a person, as a result of these experiences?

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Who do you go to for help in times of trouble? Who goes to you for help?

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Give examples of times when you've really felt proud of yourself?

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Give examples of any activity meaningful to you that you participate in (ex. education, employment, volunteering, program, etc.).

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**Section 6: CHALLENGING ISSUES\***

We ask you the following questions so that we can work with you to ensure you have the supports you need. You will still be considered for housing if you have struggled with one or more of the following issues. If you have not had any difficulties with the issues listed below, you do not have to complete this section.

Issues you sometimes struggle with:	Yes	When was the last occurrence:		
		Last 6 months	6 months to 1 year	1 to 5 years ago
Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use that has caused harm to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug use that has caused harm to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of attention while smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mishandling fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault - Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault - Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with anger control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate sexual behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse of property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Issues with collecting things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'Yes' to any of the above, please help us to understand what happened and what support you now have or may need to deal with this challenge:

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**Section 7: WHAT SUPPORTS DO YOU HAVE?** PLEASE PRINT CLEARLY!

Please describe any supports that you have in your life (e.g. family, friends, faith community, cultural/community groups, other community supports):

\_\_\_\_\_  
\_\_\_\_\_

Are you currently working with any service providers (i.e. case workers, ACT teams, etc.)?  Yes  No

If yes, please provide the following information on each service provider with whom you are working:

First Agency's Name: \_\_\_\_\_

Name/Contact Person: \_\_\_\_\_

Services Received: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Frequency of Contact: \_\_\_\_\_ Do you give consent for him/her to be contacted?  Yes  No

Second Agency's Name: \_\_\_\_\_

Name/Contact Person: \_\_\_\_\_

Services Received: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Frequency of Contact: \_\_\_\_\_ Do you give consent for him/her to be contacted?  Yes  No

Do you have a physician (e.g. GP, family doctor, walk-in clinic doctor)?  Yes  No

If yes, please provide his/her contact information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Do you give consent for him/her to be contacted?  Yes  No

Do you have a psychiatrist?  Yes  No

If yes, please provide his/her contact information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Do you give consent for him/her to be contacted?  Yes  No

## Section 8: WHAT EXTRA SUPPORTS MIGHT YOU NEED?

What kind of support do you think you need (please select ONE)?

24-Hour  
  Daily  
  Weekly  
  Other - specify:

Would you like extra support with any of the following:

	Some	A Lot
Self-managing medication	<input type="checkbox"/>	<input type="checkbox"/>
Financial responsibilities	<input type="checkbox"/>	<input type="checkbox"/>
Self-care	<input type="checkbox"/>	<input type="checkbox"/>
Using transportation / TTC	<input type="checkbox"/>	<input type="checkbox"/>
Developing positive relationships	<input type="checkbox"/>	<input type="checkbox"/>
Meeting new people	<input type="checkbox"/>	<input type="checkbox"/>
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Looking after your home	<input type="checkbox"/>	<input type="checkbox"/>
Adding structure to your day	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes education	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition and diet information	<input type="checkbox"/>	<input type="checkbox"/>
Getting to appointments	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding unsafe situations	<input type="checkbox"/>	<input type="checkbox"/>
Wellness Recovery Action Planning	<input type="checkbox"/>	<input type="checkbox"/>
Understanding English, reading, writing, literacy skills	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health and education	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding crisis and dealing with anger	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with drug or alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Improving employability & career possibilities	<input type="checkbox"/>	<input type="checkbox"/>
Education/training	<input type="checkbox"/>	<input type="checkbox"/>
Self-advocacy - knowing your rights	<input type="checkbox"/>	<input type="checkbox"/>
Other areas (please describe:)		
_____		
_____		

## Section 9: LEGAL INVOLVEMENT\*

Please complete the following questions if you have or have had legal involvement.

Please describe the legal involvement (i.e. dates, nature of incidence, etc.):

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Please complete the following questions if you have *current* 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)

Outcomes\*:  Charges withdrawn  Conditional sentence  
 Stay of proceedings  Restraining order  
 Awaiting sentence  Peace bond  
 NCR  Suspended sentence  
 Conditional discharge

Custody Status\*:  ORB detained - community access  On probation  
 ORB conditional discharge  Incarcerated  
 On parole

Other\*:  No legal problem (includes absolute discharge and end of sentence)  
 Other criminal/legal problems  Unknown

**Section 10: CONTACT INFORMATION**

**Alternative Contact Information**

If a unit becomes available, or we need to update your file, and cannot reach you, is there someone else we can contact?

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Do you have someone supporting you with organizing your finances (i.e. a Public Trustee, Power of Attorney, family member, friend, agency, etc.)? If yes, please provide the following details:**

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ File number (if any): \_\_\_\_\_

**Section 11: INCOME INFORMATION\***

**PLEASE PRINT CLEARLY!**

Most participating agencies provide rent-geared-to-income and other subsidized housing and have to determine income eligibility. Please check off the sources of income that you currently receive, and state the amount (gross amounts - i.e. before deductions):

Income Source	Monthly Amount (round to nearest dollar)
<input type="checkbox"/> Employment	_____
<input type="checkbox"/> Employment Insurance (EI)	_____
<input type="checkbox"/> Family	_____
<input type="checkbox"/> Canadian Pension Plan (CPP)	_____
<input type="checkbox"/> Ontario Disability Support Program (ODSP)	_____
<input type="checkbox"/> Disability Assistance	_____
<input type="checkbox"/> Social Assistance (Ontario Works)	_____
<input type="checkbox"/> No source of income at this time	<input type="checkbox"/> Please check if you have no source of income
<input type="checkbox"/> Other: _____	_____
<b>TOTAL:</b>	_____

If you have applied for one of the above sources, but are not yet receiving it, please provide details (i.e. application status and application date):

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If you have any personal assets (i.e. bank balances, trust funds, stocks, bonds, etc.), please describe them below:

Asset Type	Total Value
_____	_____
_____	_____

## Section 12: YOUR DECLARATION AND CONSENT

This is your agreement with us. We will respect the confidentiality of the personal information that you provide to us. You agree to what is set out below. Please read it carefully before signing.

I, \_\_\_\_\_  
(print name of applicant)

have done my best to ensure the information provided in this application is correct and am applying for supportive housing for \_\_\_\_\_ [indicate self, or name of proposed tenant].

I give my consent for the Toronto Mental Health and Addictions Supportive Housing Network (Network) and the agencies comprising the Network to collect all relevant information contained in the records maintained by the following sources in order to confirm the information set out in this application:

- o The City of Toronto (to confirm that I receive income from the Ontario Works (OW) and the amount received);
- o The Ministry of Community and Social Services (to confirm that I receive income from the Ontario Disability Support Program (ODSP) and the amount received);
- o The Network Agencies and housing providers to which I am referred to, and/or where I am housed, and/or where I have been housed;
- o The psychiatrist, physician, other support agencies, and the public trustee/power of attorney listed on my application, where I have indicated that these person(s)/agencies may be contacted as set out in section 7 of this application; and
- o The referrer listed below.

I also give my consent for the Network and Network Agencies to disclose all relevant information from any of the above listed sources as well as this application form to Network agencies and their housing providers for the purpose of arranging and maintaining housing for me.

I may withdraw or amend this consent at any time in writing, except where information has already been shared. I also understand that the Network or Network Agencies may be required at law to disclose personal information to a party other than those listed above without my consent.

I understand that a Landlord Reference Check may be completed, and files from previous tenancies may be examined in order to locate an appropriate housing placement.

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

If the applicant is a substitute decision maker for the proposed tenant, then the references to information relate to information in respect of the proposed tenant. The substitute decision maker (SDM), if any, 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 proposed tenant.

**Applicant's Signature:** \_\_\_\_\_

**Date:**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
DAY MONTH YEAR

Substitute Decision Maker:

Name: \_\_\_\_\_

Witness : \_\_\_\_\_

The information provided will be combined with information provided by other clients of the Coordinated Access to Supportive Housing program. The proposed tenant will not be identified in the data collection and no report that identifies the proposed tenant will be made. This information is used for statistics required by funders of the Network for program review and evaluation. I agree to provide information for the Network Data Collection

**Applicant's Signature:** \_\_\_\_\_

**Date:**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
DAY MONTH YEAR

Substitute Decision Maker:

Name: \_\_\_\_\_

Witness: \_\_\_\_\_

**Section 13: REFERRING AGENCY/WORKER INFORMATION\***

Although the Network Office accepts self-referrals, many of our housing providers only accept professional referrals. If another person is referring you, please have them fill in the following information, and sign below.

Relationship to applicant: \_\_\_\_\_

How well do you know the applicant? \_\_\_\_\_

How many contacts do you have with the applicant per month? \_\_\_\_\_ (days)

Do you intend to remain involved with the applicant if he/she secures housing?  Yes  No

If yes, please describe the level of involvement that you intend to maintain:

\_\_\_\_\_  
\_\_\_\_\_

Has an OCAN been completed on this applicant?  Yes  No  Unknown

**Section 14: REFERRER'S STATEMENT**

To the best of my knowledge and belief, after carefully reviewing the information available to me, the information contained in this application is complete and correct.

Some of the housing providers have congregate living situations, with minimal supervision and, in some cases shared bedrooms. Based upon my knowledge of the Applicant and my careful review of the information available to me, my assessment is that this is an appropriate referral for the applicant's desired housing choices (in section 2).

I have known the applicant for the following length of time: \_\_\_\_\_

Referrer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
DAY MONTH YEAR

Name (PRINT): \_\_\_\_\_

Position: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_