True Experience Supportive Housing and Community Work Program
201 Forest Street East, Dunnville, ON N1A 3G5
Tele: 905.774.6165
Fax: 905.774.4620

APPLICATION FOR SERVICE

PLEASE NOTE: We are dedicated to protecting the privacy of every individual we serve. All information provided is considered personal and confidential.

APPLICANT INFORMATION

LAST NAME		FIRST NAME
PRESENT ADDRESS	APARTMENT #	P.O. BOX
CITY/TOWN		POSTAL CODE
HOME TEL. #		CELL #

EMAIL ADDRESS:

DAY	MONTH	YEAR	S.I.N. #	ODSP #	HEALTH CARD #
DATE OF BIRTH					

ODSP WORKER NAME	ODSP CONTACT TEL. #

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME		RELATIONSHIP
ADDRESS	TOWN/CITY	POSTAL CODE
HOME TEL. #	CELL #	EMAIL ADDRESS

PERSONAL INFORMATION

Gender	Aboriginal Origin: ☐ Aboriginal ☐ Non Aboriginal	Marital Status	Preferred Language

SOURCE OF INCOME			CURRENT LIVING ARRANGEMENTS							
ODSP	OW	Other	☐ Children	☐ Non Relative	☐ Parents	☐ Relative	☐ Self	☐ Spouse/ Partner	☐ Other Specify

RESIDENCE TYPE							
☐ Private House	☐ Municipal Non-Profit Housing	☐ Hospital General	☐ Hospital Psychiatric	☐ Correction Facility	☐ ‹irement Home	☐ Nursing Home	☐ ›upportive Housing
☐ Hostel	☐ Boarding Home	☐ Other	PleaseSpecify				

REFERRING AGENCY/FAMILY MEMBER/GUARDIAN		
SOCIAL WORKER, FAMILY MEMBER- GUARDIAN NAME	EMAIL ADDRESS	
ADDRESS	TOWN/CITY	POSTAL CODE
Work-Home Tel. #	Cell #	Fax #

MEDICAL INFORMATION	
DIAGNOSIS/MEDICAL CONDITION	CURRENT MEDICTIONS

Have you ever been hospitalized for psychiatric reasons?	YES	NO
If Yes Explain:		

Total # of Episodes	Total # hospitalizations days	Most recent date you were hospitalizationfor Psychiatric reasons

About You

Special Interests:

Special Skills:

What are your goals?

Please select which program you are interested in: □ **Work Program** □ **Supportive Housing** □**Both**

Notice

Please be advised that upon entry into our program, you may be asked to complete an Ontario Common Assessment of Need (OCAN). Although participation is not mandatory, we would greatly appreciate your input. More information will be provided at the time of assessment.

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA) and our agency policies a "Consent to Disclose Form" must be completed and signed to provide (when requested) information concerning landlords, medication, physical and mental health history from your physicians, hospitals, case workers, criminal background and financial information with respect to ODSP and Ontario Works.

Signature:

(Applicant)_______________________________________**Date:**_______________________________

FOR OFFICE USE ONLY

Date Received:	Received by:
Date Reviewed:	Reviewed by:
Follow up:	Interview:
Additional Information Required:	Result: (please explain)
Reviewed by Executive Director: Date & Initial:	