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 RESIDENCY (Part 2) & APPLICATION FOR ALL PROGRAMS

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	Marital Status	Preferred Language
	☐ Aboriginal ☐ Non Aboriginal		

SOURCE OF INCOME

ODSP	OW	Other

CURRENT LIVING ARRANGEMENTS

☐ Children	☐ Non Relative	☐ Parents	☐ Relative	☐ Self	☐ Spouse/ Partner	☐ Other Specify

RESIDENCE TYPE

☐ Private House	☐ Municipal Non-Profit Housing	☐ Hospital General	☐ Hospital Psychiatric	☐ Correction Facility	☐ Retirement Home	☐ Nursing Home	☐ Supportive 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:	