TRUE EXPERIENCE

ENGAGING. EMBRACING. EMPOWERING.

Application for **Elizabeth Crescent Empower Program**

True Experience Supportive Housing and Community Work Program is subject to the ***Personal Health Information Protection Act (PHIPA)*** and as such, ensure the appropriate safeguards are in place to protect the security and privacy of personal health information within our organization.

APPLICANT INFORMATION

FIRST NAME:	LAST NAME:
CURRENT ADDRESS: CITY/TOWN: PROVINCE: POSTAL CODE:	CONTACT INFORMATION: HOME PHONE: CELL PHONE: EMAIL:
DATE OF BIRTH: _____ _____ _____ DAY MONTH YEAR HEALTH CARD NUMBER: PREFERRED LANGUAGE:	SOCIAL INSURANCE NUMBER: ODSP NUMBER: ODSP WORKER NAME & CONTACT NUMBER:

EMERGENCY CONTACT

CONTACT NAME:	CONTACT RELATIONSHIP:
ADDRESS:	TOWN/CITY:
POSTAL CODE:	HOME PHONE NUMBER:
CELL PHONE NUMBER:	EMAIL:

CURRENT RESIDENCE

Private Home	
Non-Profit Housing	
Hospital (General)	
Hospital (Psychiatric)	
Correctional Facility	
Supportive Housing	
Hostel	
Boarding/Group Home	

Other: (please explain) _____
_____
_____

REFERRING AGENCY/FAMILY MEMBER/GUARDIAN

SOCIAL WORKER/FAMILY MEMBER/GUARDIAN:	ADDRESS:
TOWN/CITY:	POSTAL CODE:
TELEPHONE:	EMAIL:
CELL PHONE:	FAX:

ADDITIONAL INFORMATION

Have you ever experienced a mental health crisis?	YES	NO
Do you have any life-threatening allergies that we need to be aware of?		
Do you require an Epipen?		

ABOUT YOU:

Special interests: _____

Special skills: _____

What are your goals: _____
_____
_____

NOTICE:

Please be advised that upon entry into our Elizabeth Crescent Empowerment 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 previous 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.

APPLICANT SIGNATURE: _____DATE: _____

FOR OFFICE USE ONLY

DATE RECEIVED:	**RECEIVED BY:**
DATE REVIEWED:	**REVIEWED BY:**
FOLLOW UP:	**INTERVIEW:**
ADDITIONAL INFO REQUESTED:	**RESULTS (please explain)**
HOUSING COORDINATOR: **DATE:**	**ECEP RSW:** **DATE:**

TRUE EXPERIENCE
Supportive Housing and Community Work Program