Wendat

"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: _____ Health Card #: _____

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

Name of Hospital Admitted on: Discharged on:

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:

☐ Employed Part Time
☐ Employed Full Time
☐ Able to Work but Unemployed
☐ Volunteer Work
☐ Other
☐ Student or Retraining
☐ Retired
☐ Unable to Work
☐ Self Employed

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

WHO DO YOU LIVE WITH?:

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