

Nipissing Mental Health Housing and Support Services

101 Worthington St. E, suite 215
 North Bay ON, P1B 1G5
 Phone: 705-476-4088
 Fax: 705-495-3585



Specialized Housing Application Form

This application includes all of Nipissing Mental Health Housing and Support Services Specialized Housing programs. You only need to complete one application form. Please complete ALL sections of the form. Incomplete applications will be returned to the referent and will only be reviewed once completed.

PLEASE IDENTIFY ALL APPLICABLE HOUSING OPTIONS;

- Percy Place (11 bedrooms); *Individuals with serious and persistent mental illness and complex medical issues; provides 24 hours of support*
- Lakeshore Home (8 bedrooms)- *Individuals living with Acquired Brain Injury; provides 24 hours of support*
- Transformational Home (3 bedrooms)- *Open (mental health and/or acquired brain injury); provides 8 hours of peer support daily*

APPLICANT INFORMATION

Last Name:				First Name:				Middle Name:			
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			Date of Birth (dd/mm/yyyy):							
Street Address:							Apartment/Unit #:				
City:				Province:			Postal Code:				
Phone #:				E-mail Address:							
No Fixed Address:	<input type="checkbox"/>		Health Card #:					Version Code :			
Aboriginal Status:	<input type="checkbox"/> YES <input type="checkbox"/> NO			Preferred Language:							
Marital Status :	<input type="checkbox"/> Single <input type="checkbox"/> Separated		<input type="checkbox"/> Married/Common Law <input type="checkbox"/> Widowed		<input type="checkbox"/> Divorced <input type="checkbox"/> Decline		<input type="checkbox"/> Partner/Significant other <input type="checkbox"/> Unknown				
Level of Education:	<input type="checkbox"/> No Formal Schooling <input type="checkbox"/> Some Secondary/High school <input type="checkbox"/> College/University			<input type="checkbox"/> Some Elementary/Jr. High <input type="checkbox"/> Secondary/ High school <input type="checkbox"/> Unknown			<input type="checkbox"/> Elementary/Jr. High <input type="checkbox"/> Some College/University				
Is the applicant aware of referral?	<input type="checkbox"/> YES <input type="checkbox"/> NO										

REFERRAL SOURCE

Referral Completed by:				Agency:							
Phone #:				Fax #:				Email:			

FAMILY/ CAREGIVER/ NEXT OF KIN

Full Name:				Relationship:						
Phone #:				Alternative Phone #:						
Address:				Consent to Contact:	<input type="checkbox"/> YES <input type="checkbox"/> NO					

PERSONAL HEALTH INFORMATION

Does this individual have a mental health diagnosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Specify:							
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Does this individual have a community Psychiatrist?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Name:	
Does this individual have any medical concerns?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify:	
Does this individual have a community Physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Name:	
Is this individual currently on medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Is this individual currently an inpatient in hospital?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lodge:	
Does this individual have a history of head injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
Does this individual have an Acquired Brain Injury diagnosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Does this individual use any assistive devices for mobility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify:	
Does this individual require any other assistive devices?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Specify:	
Would this individual require an accessible bedroom?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSTANCE USE			
Does this individual currently use illegal substances?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
Does this individual have a history of using illegal substances?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
Does this individual currently abuse alcohol or non- beverage alcohol (eg. rubbing alcohol)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
If yes, does this individual have a goal of either decreasing their substance use or sobriety?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Does this individual have a history of abusing alcohol or non- beverage alcohol (eg. rubbing alcohol)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
Does this individual drink socially?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:	
Is this individual willing to live in an alcohol and drug-free home?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Does this individual smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Amount:	
Is this individual willing to live in a smoke-free home?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CAPACITY			
If INCAPABLE, a Substitute Decision Maker and supporting documents are required (Any applicable forms under the Mental Health Act)			
Is this individual capable to consent to treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		
SDM Name:	Agency (if applicable):	Phone #	
Is this individual capable to release personal health information	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		
SDM Name:	Agency (if applicable):	Phone #	
Is this individual capable to manage their own finances?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown		
SDM Name:	Agency (if applicable):	Phone #	

*If capable, please indicate if this individual has completed formal Power of Attorney paperwork;				
POA for Personal Care:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
POA Name:		Relationship:		Phone #
POA for Property:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			
POA Name:		Relationship:		Phone #
INCOME				
What is the primary source of income?	<input type="checkbox"/> ODSP <input type="checkbox"/> Ontario Works <input type="checkbox"/> CPP (disability) <input type="checkbox"/> WSIB/Private <input type="checkbox"/> Other : _____			
Total monthly income amount (net)?				
LEGAL STATUS				
Legal involvement:	<input type="checkbox"/> Criminal Record <input type="checkbox"/> Not Criminally Responsible <input type="checkbox"/> Current Charges <input type="checkbox"/> No legal history			
Details:				
Does this individual have ORB conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Is this individual a registered sexual offender?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does this individual currently have a community treatment order?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RISKS *PLEASE INDICATE ANY CURRENT AND/OR HISTORICAL RISKS AND BEHAVIOURS*				
Aggression towards others	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Aggression towards property	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Self-harm	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Suicidal attempts/ideation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Sexual aggression	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Medication non-adherence	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Fire setting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Falling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Concealing a weapon	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Flight risk (wandering)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	Details:		
Please indicate any additional behaviours, stressors or triggers:				
ACTIVITIES OF DAILY LIVING				
Please indicate areas where this individual would need intensive level of support:				
<input type="checkbox"/> Medication	<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Menu Planning	<input type="checkbox"/> Grocery Shopping	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Finances	<input type="checkbox"/> Time Management	<input type="checkbox"/> Health/ Hygiene	<input type="checkbox"/> House cleaning	<input type="checkbox"/> Transportation
<input type="checkbox"/> Planning	<input type="checkbox"/> Social/Recreational Planning		<input type="checkbox"/> Interpersonal Skills	<input type="checkbox"/> Employment/education
Details:				
ADDITIONAL INFORMATION				
Has a Behavioural Therapy Assessment been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	Date:		
Has an Occupational Therapy Assessment been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	Date:		
Has a Neuropsychological Assessment been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	Date:		
Have any other relevant assessments been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	Details:		

DECLARATION AND CONSENT

All applicants must sign the declaration and consent form in order for their application to be processed.

I make the above, the following and all other, whether verbal or written representations to Nipissing Mental Health Housing and Support Services, knowing that they will be relied upon by Nipissing Mental Health Housing and Support Services to assess my qualifications for rental accommodation:

1. The information given on this form is accurate and complete as requested.
2. I understand that if I owe money (arrears) to any social housing provider and I have not made arrangements for repayments, I may not be eligible for housing.

I, _____ (print applicants full name) give consent to Nipissing Mental Health Housing and Support Services to do the following and understand that I understand that this consent will stay in effect for the duration of my involvement with Nipissing Mental Health Housing and Support Services;

1. Make any inquiries to the referring agency that it deems necessary to determine my need for support services.
2. I authorize any person, corporation, or any service agencies having knowledge of my financial information to release the information to Nipissing Mental Health Housing and Support Services in order to determine my qualification for Rent-Geared-to-Income housing.
3. Obtain and disclose information from the agencies below for the purpose of determining my need for service, housing and in assisting me with my Individual Service Plan objectives.
 - **Nipissing Mental Health Housing & Support Services (NMHSS)**
 - **People for Equal Partnership in Mental Health (PEP)**
 - **North Bay Regional Health Centre (NBRHC)**
 - **Ontario Disability Support Program (ODSP)**
 - **Ontario Public Guardian and Trustee (if applicable) (OPGT)**
 - **Medical Pharmacy**

Please identify any additional community partners if applicable (i.e. ACTT, CMHA, CHIRS etc);

- _____
- _____
- _____

Client Signature (SDM if applicable)

Date

Witness

Date