Nipissing Mental Health Housing and Support Services

222 rue est Main St. E
North Bay, ON P1B 1B1
Phone: 705-476-4088
Fax:705-495-3585

Nipissing Mental Health
Housing & Support Services
Services de logement et de soutien
en sante mentale de Nipissing
Be in a good place. Soyez dans une bonne place

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 (8 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:	☐Male ☐ Female ☐Other	Date of Birth (dd/mm/yyyy):			
Street Address:				Apartment/Unit #:	
City:		Province:		Postal Code:	
Phone #:		E-mail Address:			
No Fixed Address:	☐	Health Card #:		Version Code :	
Aboriginal Status:	☐YES ☐NO	Preferred Language:			

Marital Status :	☐ Single ☐ Separated	☐ Married/Common Law ☐ Widowed	☐ Divorced ☐ Decline	☐ Partner/Significant other ☐ Unknown
Level of Education:	☐ No Formal Schooling ☐ Some Secondary/High school ☐ College/University	☐ Some Elementary/Jr. High ☐ Secondary/ High school ☐ Unknown	☐ Elementary/Jr. High ☐ Some College/University	

Is the applicant aware of referral?	☐YES ☐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:	☐YES ☐NO

PERSONAL HEALTH INFORMATION

Does this individual have a mental health diagnosis?	☐YES ☐NO	Specify:	

Does this individual have a community Psychiatrist?	☐YES ☐NO	Name:	
Does this individual have any medical concerns?	☐YES ☐NO	Specify:	
Does this individual have a community Physician?	☐YES ☐NO	Name:	
Is this individual currently on medication?	☐YES ☐NO		
Is this individual currently an inpatient in hospital?	☐YES ☐NO	Lodge:	
Does this individual have a history of head injury?	☐YES ☐NO	Details:	
Does this individual have an Acquired Brain Injury diagnosis?	☐YES ☐NO		
Does this individual use any assistive devices for mobility?	☐YES ☐NO	Specify:	
Does this individual require any other assistive devices?	☐YES ☐NO	Specify:	
Would this individual require an accessible bedroom?	☐YES ☐NO		
SUBSTANCE USE			
Does this individual **currently use illegal substances?**	☐YES ☐NO	Details:	
Does this individual have a **history of using illegal substances?**	☐YES ☐NO	Details:	
Does this individual **currently abuse alcohol or non- beverage alcohol (eg. rubbing alcohol)?**	☐YES ☐NO	Details:	
If yes, does this individual have a goal of either decreasing their substance use or sobriety?	☐YES ☐NO		
Does this individual have a **history of abusing alcohol or non- beverage alcohol (eg. rubbing alcohol)?**	☐YES ☐NO	Details:	
Does this individual drink socially?	☐YES ☐NO	Details:	
Is this individual willing to live in an alcohol and drug-free home?	☐YES ☐NO		
Does this individual smoke?	☐YES ☐NO	Amount:	
Is this individual willing to live in a smoke-free home?	☐YES ☐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**?	☐YES ☐NO ☐Unknown				
SDM Name:		Agency (if applicable):		Phone #	
Is this individual capable to release **personal health information**	☐YES ☐NO ☐Unknown				
SDM Name:		Agency (if applicable):		Phone #	
Is this individual capable to manage their own **finances**?	☐YES ☐NO ☐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:	☐YES ☐NO ☐Unknown				
POA Name:		Relationship:		Phone #	
POA for Property:	☐YES ☐NO ☐Unknown				
POA Name:		Relationship:		Phone #	

INCOME

What is the primary source of income?	☐ODSP ☐Ontario Works ☐CPP (disability) ☐WSIB/Private ☐Other : _____
Total monthly income amount (net)?	

LEGAL STATUS

Legal involvement:	☐Criminal Record ☐Not Criminally Responsible ☐Current Charges ☐No legal history			
Details:				
Does this individual have ORB conditions?	☐YES ☐NO	Details:		
Is this individual a registered sexual offender?	☐YES ☐NO	Does this individual currently have a community treatment order?	☐YES ☐NO	

RISKS *PLEASE INDICATE ANY CURRENT AND/OR HISTORICAL RISKS AND BEHAVIOURS*

Aggression towards others	☐YES ☐NO	Details:	
Aggression towards property	☐YES ☐NO	Details:	
Self-harm	☐YES ☐NO	Details:	
Suicidal attempts/ideation	☐YES ☐NO	Details:	
Sexual aggression	☐YES ☐NO	Details:	
Medication non-adherence	☐YES ☐NO	Details:	
Fire setting	☐YES ☐NO	Details:	
Falling	☐YES ☐NO	Details:	
Concealing a weapon	☐YES ☐NO	Details:	
Flight risk (wandering)	☐YES ☐NO	Details:	
Other	☐YES ☐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:

☐ Medication ☐ Meal Preparation ☐ Menu Planning ☐ Grocery Shopping ☐ Nutrition
☐ Finances ☐ Time Management ☐ Health/ Hygiene ☐ House cleaning ☐ Transportation
☐ Planning ☐ Social/Recreational Planning ☐ Interpersonal Skills ☐ Employment/education

Details:	

ADDITIONAL INFORMATION

Has a Behavioural Therapy Assessment been completed?	☐YES ☐NO ☐Unknown	Date:	
Has an Occupational Therapy Assessment been completed?	☐YES ☐NO ☐Unknown	Date:	
Has a Neuropsychological Assessment been completed?	☐YES ☐NO ☐Unknown	Date:	
Have any other relevant assessments been completed?	☐YES ☐NO ☐Unknown	Details:	

Nipissing Mental Health
Housing & Support Services
Be in a good place.

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 (NMHHSS)**
   - **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