Housing Application

Canadian Mental Health Association, North Bay and District

222 Main St. East, North Bay, ON P1B 1B1
Tel: 705-476-4088 Fax: 705-495-3585

This application includes ALL of CMHA North Bay and District Housing programs

Please only complete 1 application form and submit to centralaccess@nbd.cmha.ca or FAX to 705-495-3585

PLEASE COMPLETE ALL SECTIONS

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 Number:			
Indigenous Status:	☐ YES ☐ NO		Preferred Language:		
Marital Status:	☐ Single ☐ Married/Common Law ☐ Divorced/Widowed				
Dependents:	☐ YES ☐ NO	If yes, number of dependents:		PLEASE COMPLETE THE SECTION ON DEPENDENT INFORMATION BELOW	
Level of Education:	☐ No Schooling/Unknown ☐ Elementary/Jr. High ☐ Secondary/ High school ☐ College/University				
Is the applicant aware of referral?	☐ YES ☐ NO				

CO-APPLICANT INFORMATION

Last Name:		First Name:		Middle Name:	
Gender:	☐ Male ☐ Female ☐ Transgendered ☐ Other _____		Date of Birth (dd/mm/yyyy):		
Street Address:				Apartment/Unit #:	
City:		Province:		Postal Code:	
Phone #:		E-mail Address:			
No Fixed Address:	☐	Health Card Number:			
Indigenous Status:	☐ YES ☐ NO		Preferred Language:		
Marital Status:	☐ Single ☐ Married/Common Law ☐ Divorced/Widowed				

Dependents:	☐YES ☐NO	If yes, number of dependents:		PLEASE COMPLETE THE SECTION ON DEPENDENT INFORMATION BELOW
Level of Education:	☐ No Schooling/Unknown ☐ Elementary/Jr. High ☐ Secondary/ High school ☐ College/University			
Is the applicant aware of referral?	☐YES ☐NO			

REFERRAL SOURCE

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

PRESENT & PREVIOUS ACCOMODATIONS

Does this individual own a home?	☐YES ☐NO	If yes, where:	
Does this individual presently live in a co-op, non-profit, or subsidized housing in Ontario	☐YES ☐NO	If yes, where:	
Has this individual ever lived in subsidized housing in Ontario?	☐YES ☐NO	Name of Provider:	
Address:	Phone #:	Move out date:	

DEPENDENT INFORMATION

NAME	AGE	BIRTHDATE	GENDER	SCHOOL	

PERSONAL HEALTH INFORMATION

Does this individual have a mental health diagnosis?	☐YES ☐NO	Specify:	
Does this individual have any medical concerns?	☐YES ☐NO	Specify:	
Is this individual currently an inpatient in hospital?	☐YES ☐NO	Lodge:	
Does this individual have an Acquired Brain Injury diagnosis?	☐YES ☐NO		
Does this individual use any assistive devices for mobility?	☐YES ☐NO	Specify:	

SUBSTANCE USE

Does this individual **currently use substances (drugs, alcohol, etc)**	☐YES ☐NO	Details:	

CAPACITY

If INCAPABLE, a Substitute Decision Maker (SDM) and supporting documents are required (Any applicable forms under the Mental Health Act)

Does the applicant have a Substitute Decision Maker (SDM)?	☐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 #	

INCOME	
What is the primary source of income? (Provide verification of each income source)	☐ODSP ☐Ontario Works ☐CPP (disability) ☐WSIB/Private ☐Other
Does this individual have a trustee?	☐YES ☐NO ☐Unknown

LEGAL STATUS	
Does this individual have ORB conditions?	☐YES ☐NO
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*			
Fire setting	☐YES ☐NO	Details:	
Other	☐YES ☐NO	Details:	
Please indicate any additional behaviors, stressors or triggers:			

ADDITIONAL INFORMATION	
Please provide any other information that is important to know re: applicant	

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 CMHA North Bay and District, knowing that they will be relied upon by CMHA North Bay and District, 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 CMHA North Bay and District, to do the following understanding that this consent will stay in effect for the duration of my involvement with CMHA North Bay and District;

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 CMHA North Bay and District, 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.
   - **Canadian Mental Health Association, North Bay and District (CMHA North Bay and District)**
   - **North Bay Regional Health Centre (NBRHC),**
   - **Ontario Disability Support Program (ODSP), DNSSAB (Ontario Works)**
   - **Ontario Public Guardian and Trustee (if applicable) (OPGT)**
   - **Medical Pharmacy**

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

   - _____
   - _____
   - _____

_____ _____
Client Signature (SDM if applicable) Date

_____ _____
Witness Date