



For Office Use Only	
Applicant Surname	Date Received

APPLICATION FOR COMMUNITY HOMES FOR OPPORTUNITY (CHO)

Community Homes for Opportunity (CHO)

CHO is a supportive housing program for people with serious mental illness. The program is intended to assist tenants by providing appropriate housing and support services to achieve and maintain stability in a safe, affordable home. The aim is to improve and/or stabilize peoples' physical and mental health and foster independence, while enhancing participation and integration into the community.

Eligibility

To be eligible for our housing program, you must meet the following criteria:

- Be 16 years of age or older
- Be diagnosed with a serious mental illness.
- Require housing and support services to live as independently as possible (may include ADL, Personal Care, housekeeping, health care, medication assistance, possibly 24-hour support)
- Experiencing homelessness or at risk of homelessness, in hospital and are unable to fully care for themselves independently due to mental illness
- Be a Canadian Citizen, Landed Immigrant (Permanent Resident), or have Refugee Claimant Status with no removal / deportation order in place
- If you own any residential property that you could live in all year, you must sell or transfer the property prior to signing a lease and accepting a unit

Privacy

We respect your privacy and only share your information with other people or organizations if you give permission. Your information may be shared if a law is in place that overrides our privacy policy. If you have questions about your information, and how it is stored or shared, please call our Privacy Officer at (905) 436-8760 ext

Wait List

Eligible applicants will be placed on a wait list. You will be removed if:

- (a) false information is given
- (b) information is withheld
- (c) we cannot contact you using the information given
- (d) you accept other subsidized housing

Housing is offered based on priority. It is your responsibility to tell us if there are changes in your housing, finances, or family structure.

Please Note:

- This form can be completed and submitted electronically
- Incomplete applications will delay the process
- Required documents (Income Verification and ID) will only be requested when a unit becomes available for you. Required Documents may include a photocopy of:
 - ID - birth certificate, health card, passport, and/or immigration documentation
 - Income Verification – most recent Notice of Assessment, OW/ODSP monthly statement, or pay stub
- After this application is received, we will send you a letter to confirm receipt
- A CMHA staff member will contact you to determine your level of priority

Send your completed application to:
Canadian Mental Health Association Durham
60 Bond Street E
Oshawa, Ontario, L1G 1A5
Phone: (905) 436-8760
Email: cmha@cmhadurham.org
Fax: 905-436-1569

SECTION A – Applicant Information

First Name		Middle Name		Last Name	
Date of Birth (dd/mm/yyyy)		Gender		Preferred Name (if different than first name)	
Address / Apt # / P.O. Box #		City, Province		Postal Code	
Phone Number			Email Address (optional)		
Permission to: <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> Leave message					
Health Card		Version Code		Expiry	
Social Insurance Number					
Marital Status		Indigenous Status		Citizenship	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		<input type="checkbox"/> Non-Indigenous <input type="checkbox"/> Indigenous – Group:		<input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Permanent Resident* <input type="checkbox"/> Refugee Claimant <input type="checkbox"/> Deportation Order *If born outside of Canada, when did you arrive?	
Community Treatment Order		Employment Status			
<input type="checkbox"/> No <input type="checkbox"/> Yes (please attach a copy)		<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed:			

SECTION B – Supports

You agree that we can contact the supports listed below by checking "Permission to Contact". You also agree that we can exchange information for the purpose of your CHO Application.

Referral Source	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Case Manager	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Family Physician	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Public Guardian Trustee	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Other Community Support	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Next of Kin or Emergency Contact	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____
Legal Representation	
Permission to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Name: _____	Contact #: _____

SECTION C – Monthly Income

Income Source	Applicant	Other Member
Ontario Disability Support Program (ODSP)		
Ontario Works (OW)		
Employment		
Canadian Pension Plan (CPP)		
Other Income - specify:		
TOTAL INCOME FROM ALL SOURCES		
If no source of income, have you applied for any social assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have assets that would disqualify you from receiving social assistance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you manage your own finances?		<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION D – Housing Information

Other Members of the Household					
Last Name	First Name	Date of Birth (dd/mm/yyyy)	Gender	Student (Y / N)	Relationship to Applicant
1.					
2.					
Present Accommodations					
<input type="checkbox"/> Own / Co-Own <input type="checkbox"/> Rented Unit <input type="checkbox"/> Subsidized Housing/Co-Op <input type="checkbox"/> Living with Family or Friends <input type="checkbox"/> Group or Care Home <input type="checkbox"/> Living on street <input type="checkbox"/> Couch Surfing <input type="checkbox"/> Hotel or Motel <input type="checkbox"/> Shelter <input type="checkbox"/> Jail: <i>Expected Release Date:</i> _____ <input type="checkbox"/> Hospital: <i>Expected Discharge Date:</i> _____ Rent: _____ Utilities: _____					
How long have you been in your current living situation? _____					
Have you ever experienced difficulty finding or keeping housing in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes; explain: _____					
Have you ever lived in Subsidized Housing before? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes; explain: _____					
Do you have arrears with CMHA or another Social Housing Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes; explain: _____					

SECTION E – Special Accommodations

Can you climb stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is a modified unit required because of a medical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- If Yes, please describe the type of unit you need: _____	

SECTION F – Health Information

List Medical Conditions/History <i>(surgery, stroke, etc.)</i>	List Physical Challenges <i>(mobility, wheelchair, walker, etc.)</i>	Allergies		
Mental Health and/or Addictions (substance use) - Please describe your diagnosis or symptoms.				
Medication History				
Medication	Dose	Frequency	Reason	Prescriber
Risks – Do you have any history of harm to self or others? (ie. suicide, aggressive or sexual behaviours, fire starting, etc)				
Legal Issues – Do you have any history of or any current legal issues?				
Supports – Check off the areas listed below that you may require support with.				
<input type="checkbox"/> Budgeting and personal administration <input type="checkbox"/> Cleanliness (organization, clutter, laundry, etc) <input type="checkbox"/> Food safe handling and storage <input type="checkbox"/> Meal planning and preparation <input type="checkbox"/> Meaningful daily activity	<input type="checkbox"/> Medication management <input type="checkbox"/> Relationships with neighbours and landlords <input type="checkbox"/> Routines and activities of daily living <input type="checkbox"/> Safety planning <input type="checkbox"/> Tenant and landlord rights and responsibilities			
Personal Relevant Family History				

SECTION F – Health Information continued

Mental State				
Orientation: Intact Impaired <i>Time</i> <input type="checkbox"/> <input type="checkbox"/> <i>Place</i> <input type="checkbox"/> <input type="checkbox"/> <i>Person</i> <input type="checkbox"/> <input type="checkbox"/>	Memory: Intact Impaired <i>Immediate</i> <input type="checkbox"/> <input type="checkbox"/> <i>Recent</i> <input type="checkbox"/> <input type="checkbox"/> <i>Long Term</i> <input type="checkbox"/> <input type="checkbox"/>			
Hallucinations: <input type="checkbox"/> Yes (<i>please explain</i>) <input type="checkbox"/> No	Concentration: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Incontinence: <input type="checkbox"/> Yes (<i>please explain</i>) <input type="checkbox"/> No	Sleep Difficulties: <input type="checkbox"/> Yes (<i>please explain</i>) <input type="checkbox"/> No			
Support Required with Activities of Daily Living				
Activity	Dependent	Independent	Requires Supervision	Requires Assistance
Hygiene / Grooming				
Bathing				
Dressing Self				
Toileting				
Feeding				
Laundry				
Medication Management				
Additional Notes				

Declaration and Consent

Representative

A representative can make certain decisions about your housing. They cannot sign a lease for you, but they can set up appointments for us to meet with you, and we can exchange information related to your housing. A representative can be a case manager, family member, trustee, or friend. **You do not have to have a representative** but, if you do, please put their contact information below and sign to indicate your consent.

Representative Name: _____ **Phone Number:** _____ **Date:** _____

- By signing below, you confirm that this application accurate and complete to the best of your knowledge. You also consent to having your information shared within CMHA Durham as needed for the purpose of this application. You agree that we can contact housing providers, organizations which manage housing wait lists, and benefits providers or employers to confirm that the information you have given us is true. You also agree that we can give those organizations any information about you that they need to find and access any record they might have on file for you.

Applicant Signature: _____ **Date:** _____