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: ❑ Call ❑ Text ❑ Leave message	

Health Card	**Version Code**	**Expiry**

Social Insurance Number

Marital Status	**Indigenous Status**	**Citizenship**
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other	❑ Non-Indigenous ❑ Indigenous – Group:	❑ Canadian Citizen ❑ Permanent Resident* ❑ Refugee Claimant ❑ Deportation Order **If born outside of Canada, when did you arrive?*

Community Treatment Order	**Employment Status**
❑ No ❑ Yes *(please attach a copy)*	❑ Unemployed ❑ 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: ❑ Yes ❑ No ❑ N/A *Name:* *Contact #:*

Case Manager	**Family Physician**
Permission to contact: ❑ Yes ❑ No ❑ N/A *Name:* ______________________ *Contact #:*	Permission to contact: ❑ Yes ❑ No ❑ N/A *Name:* ______________________ *Contact #:*
Public Guardian Trustee	**Other Community Support**
Permission to contact: ❑ Yes ❑ No ❑ N/A *Name:* ______________________ *Contact #:*	Permission to contact: ❑ Yes ❑ No ❑ N/A *Name:* ______________________ *Contact #:*
Next of Kin or Emergency Contact	**Legal Representation**
Permission to contact: ❑ Yes ❑ No ❑ N/A *Name:* ______________________ *Contact #:*	Permission to contact: ❑ Yes ❑ No ❑ 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?	❑ Yes ❑ No
Do you have assets that would disqualify you from receiving social assistance?	❑ Yes ❑ No
Do you manage your own finances?	❑ Yes ❑ 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

❑ Own / Co-Own ❑ Rented Unit ❑ Subsidized Housing/Co-Op ❑ Living with Family or Friends
❑ Group or Care Home ❑ Living on street ❑ Couch Surfing ❑ Hotel or Motel ❑ Shelter
❑ Jail: *Expected Release Date:*____________________
❑ Hospital: *Expected Discharge Date:*____________________ Rent: Utilities:

How long have you been in your current living situation? ____

Have you ever experienced difficulty finding or keeping housing in the past? ❑ Yes ❑ No

If yes; explain: ____

Have you ever lived in Subsidized Housing before? ❑ Yes ❑ No

If yes; explain: ____

Do you have arrears with CMHA or another Social Housing Provider? ❑ Yes ❑ No

If yes; explain: ____

SECTION E – Special Accommodations

Can you climb stairs?	❑ Yes ❑ No
Is a modified unit required because of a medical disability?	❑ Yes ❑ No
- If Yes, please describe the type of unit you need: ________________________________	

SECTION F – Health Information

List Medical Conditions/History *(surgery, stroke, etc.)*	**List Physical Challenges** *(mobility, wheelchair, walker, etc.)*	**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.

❑ Budgeting and personal administration	❑ Medication management
❑ Cleanliness (organization, clutter, laundry, etc)	❑ Relationships with neighbours and landlords
❑ Food safe handling and storage	❑ Routines and activities of daily living
❑ Meal planning and preparation	❑ Safety planning
❑ Meaningful daily activity	❑ Tenant and landlord rights and responsibilities

Personal Relevant Family History

SECTION F – Health Information continued

Mental State			
Orientation: *Time* / *Place* / *Person*	**Intact** ☐ ☐ ☐ **Impaired** ☐ ☐ ☐	**Memory:** *Immediate* / *Recent* / *Long Term*	**Intact** ☐ ☐ ☐ **Impaired** ☐ ☐ ☐
Hallucinations: ❑ Yes *(please explain)* ❑ No		**Concentration:** ❑ Good ❑ Fair ❑ Poor	
Incontinence: ❑ Yes *(please explain)* ❑ No		**Sleep Difficulties:** ❑ Yes *(please explain)* ❑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:_______________________________________

Canadian Mental Health Association
Durham
Mental health for all

Association canadienne pour la santé mentale
Durham
La santé mentale pour tous

Consent to Disclose Personal Health or Other Information

I,____

PRINT full name

DATE OF BIRTH Month__________ Day________ Year___________________

Hereby give my consent to allow

Canadian Mental Health Association Durham

and

Community Homes for Opportunity Homeowners

To share the following information for the purpose of providing community mental health services (please describe):

____

____

Signature of Individual _________________________________ Month_____ Day__ Year_____

Signature of Witness_________________________________ Month_____ Day____ Year_____

Expiry Date for Consent Month_________ Day______ Year_____________

Ongoing _______________________ (Initials of person giving consent)

I understand that I can withdraw my consent at any time by providing written notice for withdrawal of consent. I understand that no information will be released to other parties without my consent unless there is a legal requirement to do so or a serious concern about my safety or the safety of others.