



GLADSTONE HOUSE

1167 Gladstone Avenue Ottawa, ON

K1Y 3H7

Telephone: (613) 724-2300 FAX: (613) 422-2874

“Building Bridges to the FUTURE”

The Salvation Army Ottawa Booth Centre

171 George Street, Ottawa Ontario K1N 5W5

Telephone : (613) 241-1573 ext 306

Fax # 613-562-8117

RESIDENTIAL APPLICATION:

Please answer all questions and sign incomplete applications will be returned

DATE RECEIVED: _____

A. GENERAL INFORMATION

NAME _____ TELEPHONE _____

ADDRESS _____

HOW LONG HAVE YOU BEEN AT THIS ADDRESS? _____

REASON FOR LEAVING PRESENT ADDRESS? _____

HAVE YOU EVER LIVED IN SECOND STAGE HOUSE? YES _____ NO _____
FROM _____ TO _____

GENDER: ____ DATE OF BIRTH: D ____ /M ____ /Y ____ AGE: _____

FIRST CHOICE LANGUAGE SPOKEN: _____ SECOND: _____

IN CASE OF EMERGENCY CONTACT

NAME: _____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

TELEPHONE: HOME _____ BUSINESS: _____

B. PRESENT SITUATION

AT THE PRESENT TIME I LIVE: 1) WITH FRIENDS _____ 2) WITH FAMILY _____
3) ALONE _____ 4) WITHIN A GROUP _____

COST OF ACCOMMODATION _____

NAME OF LANDLORD _____ TELEPHONE _____

C. FINANCIAL SITUATION (indicate gross income per month)

EMPLOYMENT _____ OWA _____ ODSP _____ PENSION _____
PERSONAL SAVINGS _____ OSAP _____ INSURANCE BENEFITS _____
LIVING ALLOWANCE _____ OTHER _____

(IF YOUR INCOME IS OWA OR ODSP , PROVIDE THE NAME/PHONE# OF YOUR WORKER)

NAME _____ TELEPHONE _____

DAYS AND TIMES TO REACH YOUR WORKER _____

D. LIVING WITH OTHERS

HAVE YOU LIVED IN A GROUP SETTING PRIOR TO THIS DATE? YES ____ NO ____

IF YES, WITH WHOM? _____

WHY DO YOU WANT TO LIVE AT THE S.A. GLADSTONE HOUSE _____

HOW DO YOU FEEL ABOUT SHARING A KITCHEN/LIVING ROOM/BATHROOM ?

BRIEFLY DESCRIBE SOME OF YOUR COOKING SKILLS: _____

E. ACTIVITIES: PLEASE CHECK ACTIVITIES IN WHICH YOU ARE INVOLVED

VOLUNTEER WORK _____ EMPLOYMENT _____ SCHOOL/TRAINING _____
RECREATION _____ THERAPY _____ AA/NA MEETINGS _____ SUPPORT GROUP _____ LIFE
SKILLS TRAINING _____ OTHER (name it) _____

NAME EACH OF THE AGENCIES/SCHOOLS/EMPLOYERS/MEETINGS/THERAPISTS etc.

STATE THE DAYS & TIMES OF INVOLVEMENT IN EACH ACTIVITY:

F. MEDICAL HISTORY: O.H.I.P. NUMBER _____

NAME OF FAMILY DOCTOR: _____ TELEPHONE: _____

ADDRESS: _____

DO YOU LIVE WITH A MEDICAL CONDITION OF ANY KIND? (DIABETES; HEART
CONDITION; HEPATITIS ETC.) YES: _____; NO: _____ IF YES, PLEASE SPECIFY:

DO YOU TAKE MEDICATION FOR YOUR CONDITION? YES _____: NO: _____

MEDICATIONS: _____

DO YOU LIVE WITH AN EMOTIONAL AND/OR MENTAL HEALTH DIAGNOSIS?
NO: _____ YES: _____ IF YES, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

WHAT IS YOUR DIAGNOSIS? _____

NAME OF PSYCHIATRIST/PSYCHOLOGIST _____

ADDRESS/CLINIC/HOSPITAL _____ TEL. NO. _____

HOW OFTEN DO YOU SEE YOUR PSYCHIATRIST/PSYCHOLOGIST? _____

ARE YOU CURRENTLY TAKING MEDICATION? YES _____ NO _____

IF YES, WHAT MEDICATION(S): _____

HOW LONG HAVE YOU BEEN TAKING MEDICATION? _____

WHEN DO YOU TAKE YOUR MEDICATION? _____

DO YOU HAVE A SOCIAL WORKER FOR ADDITIONAL SUPPORT? YES ___ NO ___

NAME _____ AGENCY _____ TEL.NO. _____

DO YOU LIVE WITH A CHEMICAL ADDICTION DIAGNOSIS? NO _____ YES _____

IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS.

WHAT IS YOUR SUBSTANCE(S) OF CHOICE?: _____

HOW LONG HAVE YOU NOT USED DRUGS AND/OR ALCOHOL? _____

ARE YOU RECEIVING COUNSELLING AT THIS TIME? NO _____ YES _____

NAME OF AGENCY OR CENTRE _____

NAME OF COUNSELLOR _____ TEL. NO. _____

G. HISTORY OF CRIMINAL OFFENCES:

ARE YOU ON PROBATION/PAROLE _____

IF YES, LIST OFFENCE(S) AND TIME PROB./PAROLE IS COMPLETED _____

LIST ANY OFFENSES FOR WHICH YOU WERE CHARGED OR CONVICTED IN THE PAST TEN YEARS: _____

-

-

-

NAME AND NUMBER OF PROBATION/PAROLE OFFICER: _____

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H. REFERENCES: YOU MUST PROVIDE 3 REFERENCES WITH ACCURATE PHONE NUMBERS: (Friends and family members excluded)

LANDLORD: _____ TELEPHONE: _____

PSYCHIATRIST/ _____ TELEPHONE: _____
PSYCHOLOGIST

SOCIAL WORKER/: _____ TELEPHONE: _____
COUNSELOR

OUTREACH WORKER: _____ TELEPHONE: _____

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FAMILY DOCTOR: _____ TELEPHONE: _____

EMPLOYER: _____ TELEPHONE: _____

VOUNTEER _____ TELEPHONE: _____
SUPERVISOR:

TEACHER: _____ TELEPHONE: _____

OTHER: _____ TELEPHONE: _____

I. REFERRED TO GLADSTONE HOUSE BY:

NAME: _____ TELEPHONE: _____

AGENCY (IF APPLICABLE): _____

I CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT. I UNDERSTAND THAT ANY MISLEADING INFORMATION COULD BE GROUNDS FOR TERMINATION OF THE GLADSTONE HOUSE APPLICATION PROCESS AND/OR RESIDENCY.

SIGNATURE: _____ DATE: _____

IF SOMEONE OTHER THAN THE APPLICANT HAS FILLED OUT THIS APPLICATION, PLEASE SIGN HERE _____

NAME: _____

TITLE: _____

ORGANIZATION: _____