TRANSITIONAL 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 A TRANSITIONAL 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 _____ 5) PROGRAM_____

COST OF ACCOMMONDATION_____

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. TRANSITION HOUSE_____
_____

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

E. <u>ACTIVITIES:</u> 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. <u>MEDICAL HISTORY</u>: 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 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 AN 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:_____
_____
_

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

LANDLORD: _____ TELEPHONE: _____

PSYCHIATRIST/ PSYCHOLOGIST _____ TELEPHONE: _____

SOCIAL WORKER/: COUNSELOR _____ TELEPHONE: _____

OUTREACH WORKER: _____ TELEPHONE: _____

FAMILY DOCTOR: _____ TELEPHONE: _____

EMPLOYER: _____ TELEPHONE: _____

VOUNTEER SUPERVISOR: _____ TELEPHONE: _____

TEACHER: _____ TELEPHONE: _____

OTHER:_____ TELEPHONE: _____

I. REFERRED TO TRANSITION 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 TRANSITION 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:_____

Revised Feb 2004