MCEWAN HOUSING AND SUPPORT SERVICES
20 DUNDONALD STREET, TORONTO, ONTARIO M4Y2K1
TELEPHONE: 416-929-6228 • FAX: 416-972-0503

Coordinated Application Form

Select all that apply:
☐ Service Coordination Program (12 Partner Project[1])
☐ Addictions Supportive Housing (A Partnership with FIFE House)
☐ Mental Health Community Support Program
☐ Residential Support Program ☐ Transgender Program (BLOOM)

Applicant Full Name ________________________________ D.O.B. ___/____/______
Applicants Legal name (if different)________________________ DD MM YYYY

Current Housing Situation ____

Address (or mailing address) ____

Applicant's cell phone/contact number (if any)

____

(If applicable) partner/friend ______________ Relationship _________________

Partner/friend's phone number(s) ____

OHIP___________-_________-________VC____ SIN________-_________-___________

Gender: ( ) Female ( ) Male ( ) Trans-Female ( ) Trans-Male ( ) Other

Source of Income: Work☐$___________ ODSP☐$___________ OW☐$_______

CPP ☐$__________ Private Disability ☐$__________ Other☐$__________

Status: ☐Canadian Citizen, ☐ Landed Immigrant, ☐ Refugee / Protected Person

☐ Refugee Claimant.

Native Language_________________ Preferred Language_____________________

Cultural Background ____________________ Religion _______________________

Highest Education Level ____

Referring Agency ____

Contact Name ________________________Contact# _______________________

Referral Reason ☐HIV ☐Homelessness ☐Physical Health Crisis

☐Mental Health Challenges ☐ Substance Use Challenges ☐ Other ________________

If the Referral source is a Hospital, please attach the Discharge Paperwork.

____

Immediate Health Concerns____

____

Health Conditions (HIV/AIDS, Hepatitis, Diabetes, TB, Etc.) ___

____

Last TB testing date: ________________________ Results: _______________________

Family Dr's Name______________________________ Phone #______________________

Address ____

Specialist Name______________________________ Phone #______________________

Address____________________________________ Spec. Area ______________________

Specialist Name______________________________ Phone #______________________

Address____________________________________ Spec. Area ______________________

Medication Regimen (1.HAART, 2.Mental Health Meds, 3.Others)

1. ____
2. ____
3. ____

Drug / Food allergies ____

Pharmacy Name_______________________ Address/Phone________________________

Mental Health Diagnosis _________________________ , __________________________

Age of Onset _____________ Date of 1st Mental Health Hospitalization ________________

Number of Mental Health Hospitalizations in the last 2 years ______ total of days _______

Currently on treatment: ☐ Yes ☐ No. If "Yes" where? _____________________________

Substance/Alcohol Use__________________ __________________ ________________

Currently in treatment: ☐ Yes ☐ No. If "Yes" where? _______________________________

Substance/ Alcohol Use Frequency ____

____

Legal Involvement: ☐ Yes ☐ No. If "Yes" please comment_________________________

____

Have you ever displayed the following behaviours?

☐Suicidal ☐Self-Abusive ☐ Aggressive ☐ Assault

Comment (e.g.: circumstances at the time, how long ago? etc)_______________________

____

____

Emergency Contact ______________________ Phone #___________________________

Address____

Next of Kin ___________________________ Phone# _____________________________

Address____

1. Number of visits to Emergency in the last year________
2. Number of hospitalizations in the last year_________

   Total number of impatient days in the last year__________
3. Number of withdrawal management admissions in the last year________
4. Number of "Day Program" admissions in the last year ________
5. Number of arrests in the last year _____________

   Total of days served in the last year_____________
6. Do you owe money to a Social Housing Provider? _______________________________

______________________________ ______________________________

Client Printed Name Client Signature

______________________________ ______________________________

Referral Source Printed Name Referral Source Signature

Date ____ / ____ / _______
DD MM YYYY

For McEwan Housing and Support Services Use Only

Recommended to ____ Program

Comment____

____

____

____

McEwan Housing & Support Services
Consent/Authorization

I, ____, agree to provide LOFT Community Services with consent to collect information about me as necessary while a client of LOFT Community Services.
I give consent/authorization to LOFT to contact other agencies/ individuals to obtain or verify information relevant to my care and support as a client of LOFT.
The agencies or individuals LOFT can contact about my care are:

- Health Clinics and Hospitals
- Doctors, including Specialists
- Community agencies
- Please note specific involved agencies:
  ____
  ____
  ____

I further give permission to such other agencies/organizations with which I may be involved to provide information to LOFT relevant to my care and support as a client of LOFT, and/or for advocacy on my behalf as indicated.
I may revoke consent/authorization to collect/share information at anytime and agree to do so in writing. This agreement applies only while receiving services.
This consent expires in one year from the date of signing.

______________________________ ______________________________
Name (Printed) Signature

______________________________ ______________________________
Witness (Name and Title) Signature (Witness)

____
Date