

Application	
Application Type: <input type="checkbox"/> New <input type="checkbox"/> Update	Date:
<input type="checkbox"/> I confirm that I have written and/or provide verbal consent to disclose the information contained in this form with a variety of community stakeholders as it pertains to the Lanark County By Names Prioritized List administered and managed by the Lanark County.	
<input type="checkbox"/> I withdraw my consent to disclose information contained in the Lanark County By Names Prioritized List administered and managed by the Lanark County.	

Note: If update is selected, only completed the fields that have changed, including all required fields. If available, also include applicant's date of birth.

Applicant	
Unique Identifier: If unknown, enter N/A	Member ID#:
First Name:	Last Name:
Preferred Name:	Preferred Language:
Street:	City:
Province:	Country:
Phone Number:	Email:
Preferred contact method:	Gender Identity: Preferred Pronouns:
Date of Birth:	Age: <input type="checkbox"/> Unsure <input type="checkbox"/> Declined

Alternate Contact Information	
First Name:	Last Name:
Phone Number:	
<input type="checkbox"/> (Check if Yes). Do we have your permission to speak to this person regarding you and the personal and confidential information in this form?	

Partner/Spouse	
First Name:	Last Name:
Preferred Name:	Preferred Pronouns:
Date of Birth:	Age: <input type="checkbox"/> Unsure <input type="checkbox"/> Declined
Would you like to access supports and services with your partner?	

Additional Information		
Household Type:	Children in Household?	Number of Children in Household?
Expecting?	Veteran?	
Indigenous Status Identified?	Indigenous Services Requested?	

Housing History

Current Sleeping Arrangements:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Couch Surfing | <input type="checkbox"/> Hotel/Motel | <input type="checkbox"/> Hostel |
| <input type="checkbox"/> Public institution: correctional facilities | <input type="checkbox"/> Public institution: hospital and/or treatment program | |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Transitional housing | <input type="checkbox"/> Unsheltered |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Not filled | |

Community Currently Residing in/Connected to? _____

Which community do you consider to be your home / did you come from?

- Township of Tay Valley
- Township of Drummond North Elmsley
- Township of Montague
- Town of Perth
- Township of Lanark Highlands
- Town of Smiths Falls
- Township of Mississippi Mills
- Town of Carleton Place

Number of months experiencing homelessness in past **year (12 months total):**

Number of months experiencing homelessness in past **3 year (36 months total):**

Additional Comments:

Source of Income

- | | | | |
|---|--|-------------------------------|--|
| <input type="checkbox"/> OW | <input type="checkbox"/> ODSP | <input type="checkbox"/> OSAP | <input type="checkbox"/> Self-Employment |
| <input type="checkbox"/> CPP | <input type="checkbox"/> OAS | <input type="checkbox"/> GIS | <input type="checkbox"/> WSIB |
| <input type="checkbox"/> Employment Insurance | <input type="checkbox"/> Veteran Pension | | |

Services Requested

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Housing | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Addictions | <input type="checkbox"/> Financial Aid |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Health care | <input type="checkbox"/> Counselling | <input type="checkbox"/> Dentistry |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Life Skills | <input type="checkbox"/> Case Management | <input type="checkbox"/> Trusteeship |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Agency: _____ | |

Additional Comments:

Financial Supports Requested

- | | |
|--|---|
| <input type="checkbox"/> Housing Options Program | <input type="checkbox"/> OW Discretionary Funding |
| <input type="checkbox"/> Emergency Accommodation | <input type="checkbox"/> |
| <input type="checkbox"/> Gift Card | <input type="checkbox"/> |

Additional Comments:

Assessment

Please indicate the individual or family's current homelessness status:

- Chronic homelessness** – Continually homeless for a year or more OR 4+ episodes of homelessness in the past 3 years, due to complex and persistent barriers related to health, mental health, and substance use.
- Episodic homelessness** – Homeless for less than a year AND <4 episodes of homelessness in the past 3 years, due to complex issues such as addictions or family violence.
- Transitional homelessness** – Homeless for the first time OR <2 episodes of homelessness in the past 3 years, generally due to economic or housing challenges, requiring minimal and one-time assistance.
- Imminent risk of homelessness** – Housed, but do not have safe and appropriate housing for at least two months and do not have the resources or support networks necessary to avoid homelessness.
- None of the above**, please specify: _____

In the past year (12 months) have you:

- | | | | |
|---|-------------|----------|-------|
| a. Been to an emergency room? | Y__ N__ #__ | Refused* | _____ |
| b. Been hospitalized? | Y__ N__ #__ | Refused | _____ |
| c. Interacted with police (tickets, arrest, searches) | Y__ N__ #__ | Refused | _____ |
| d. Been to prison / jail | Y__ N__ #__ | Refused | _____ |
| e. Interacted with crisis services, including: | Y__ N__ #__ | Refused | _____ |
| ~ Sexual assault crisis, mental health crisis, family / Intimate violence, distress centers and Suicide prevention hotlines | | | |

Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

- | | | | |
|--|---------|---------|-------|
| a. A mental health issue or concern? | Y__ N__ | Refused | _____ |
| b. Substance abuse? | Y__ N__ | Refused | _____ |
| c. A past head injury? | Y__ N__ | Refused | _____ |
| d. A learning disability, developmental disability, or other impairment? | Y__ N__ | Refused | _____ |
| e. A physical disability? | Y__ N__ | Refused | _____ |
| f. Relationship breakdown | Y__ N__ | Refused | _____ |

What challenges or problems have you experienced when trying to find housing? (select all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Low income | <input type="checkbox"/> Mental Health issues | <input type="checkbox"/> Accessibility Needs |
| <input type="checkbox"/> No income assistance | <input type="checkbox"/> Addiction | <input type="checkbox"/> Discrimination |
| <input type="checkbox"/> Rents too high | <input type="checkbox"/> Family breakdown / conflict | <input type="checkbox"/> Don't want housing |
| <input type="checkbox"/> Poor housing conditions | <input type="checkbox"/> Criminal history | <input type="checkbox"/> No barriers to housing |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Pets | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Health / disability issues | <input type="checkbox"/> Children | <input type="checkbox"/> Other: |

Additional Comments:

Agency Match/Housing Updates/Other Information

Name of the staff submitting the form: _____

Assigned Agency:

Program Name:

Date Documents Collected:

Service Provision Refused

Date Refused:

Date Housed:

Housing Type:

Housing Location:

Other – specify:

Date of Last Contact:

Date Left Community:

Date Deceased:

Additional Comments: