

**SUMMIT HOUSING & OUTREACH PROGRAMS  
PRELIMINARY CLIENT PROFILE SUMMARY**

*Please fill out the information below in order for us to determine suitability of this individual for housing under the Summit Housing & Outreach Programs.*

**Name of Individual:** \_\_\_\_\_ **Date of Application:** \_\_\_\_\_

Does this person have a serious mental illness? Yes    No

Is this person currently residing in a hostel or shelter? Yes    No

Has this person previously resided in a hostel or shelter? Yes    No

Is this person at risk of losing their present accommodation? Yes    No

If yes, please explain: \_\_\_\_\_

Is this person over 16 years of age? Yes    No

Does he/she have links to the community (i.e.: family, doctor, previous address) Yes    No

Would he/she be willing to relocate? Yes    No

What's the primary issue that makes it difficult for this individual to maintain independent living/housing? Please explain: \_\_\_\_\_

Are you aware of any safety concerns which a caseworker should be conscious when working with this individual? Yes    No

Please elaborate: \_\_\_\_\_

Have you provided this person with information about the Summit Housing & Outreach Programs?  
Program? Yes    No

How can we contact this person at a later date? \_\_\_\_\_

Is there any other information that you would like to provide regarding this individual? Please do so below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please send the above information to:

Summit Housing & Outreach Programs  
760 Brant Street, Suite 405A  
Burlington, Ontario  
L7R 4B7

Phone: 905-333-4814  
Fax: 905-333-6782  
Email: [info@summit-housing.ca](mailto:info@summit-housing.ca)

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**Application for Supportive Housing and Outreach Programs**  
**THE FOLLOWING QUESTIONS ARE MINISTRY OF HEALTH AND LONG-TERM CARE REQUIREMENTS.**

**Date:** \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone: \_\_\_\_\_

*Please provide as much background information as possible on the referred individual in order for us to determine suitability and to provide the most appropriate level of support. **Please print in ink.***

Housing & Support Referral       Outreach Support Referral

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Health Card #: \_\_\_\_\_  
DD/MM/YYYY

Is applicant a permanent resident of Ontario? \_\_\_\_\_

Sex: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Marital Status: \_\_\_\_\_ S.I.N. #: \_\_\_\_\_

Does individual have a serious mental illness as defined in the most recent DSM Manual? Yes    No

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Has individual been educated regarding her/his diagnosis? Yes    No

Level of insight?    Complete ( )    Somewhat ( )    None ( )

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_  
(i.e. Not Hospital)

Frequency of Contact: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Frequency of Contact: \_\_\_\_\_

Other Support Services Involved (please indicate contact person and phone number):

\_\_\_\_\_  
\_\_\_\_\_

Please indicate if there will be an on-going liaison person(s): Yes/No

Name: \_\_\_\_\_

Agency (if applicable): \_\_\_\_\_ Phone #: \_\_\_\_\_

Frequency of Client Contact: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

**CLIENT INFORMATION**

**1. Client's Present Living Situation:** \_\_\_\_\_

Employment Status: \_\_\_\_\_

Income: OW: \$ \_\_\_\_\_ ODSP: \$ \_\_\_\_\_

CPP: \$ \_\_\_\_\_ Private Pension: \$ \_\_\_\_\_

Employment Income: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

RRSP's/Annuities/Investment income: \$ \_\_\_\_\_

*Please indicate monthly amounts where applicable.*

**Halton Homes Program only:**

Will children reside with the client: \_\_\_\_\_ (If yes, please indicate number, and age) –

\_\_\_\_\_

**2. Please give a brief profile/relevant history of this individual** (e.g.: personality characteristics, illness symptoms, current issues of concern).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Presenting Problems: (Please select all that apply at time of application)

- |  |  |
|--|--|
| <input type="checkbox"/> Drug Abuse (illegal/prescription) | <input type="checkbox"/> Hallucinations/Delusions    |
| <input type="checkbox"/> Alcohol Abuse                     | <input type="checkbox"/> Judicial Involvement        |
| <input type="checkbox"/> Suicidal ideations/attempts       | <input type="checkbox"/> Difficulty with Life Skills |
| <input type="checkbox"/> Arson (fire setting)              | <input type="checkbox"/> Social Inappropriateness    |
| <input type="checkbox"/> Psychosomatic symptoms            | <input type="checkbox"/> Property Damage             |
| <input type="checkbox"/> Violence towards self/others      | <input type="checkbox"/> Gambling                    |

Please Elaborate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Does the applicant have a history of suicidal behaviour/threats? Yes/No**  
**If yes to either of the above, please provide details.**

a) Pattern and Circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b) Last Occurrence: \_\_\_\_\_

**4. (a) Does the applicant have a history of drug and/or alcohol dependency or abuse? Yes/No**  
**If yes, please provide details.**

a) Pattern and Circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b) Current Situation (e.g.:Support Group,Treatment): \_\_\_\_\_  
\_\_\_\_\_

**4. (b) Does the applicant have a family history of drug and/or alcohol abuse (e.g. parents, siblings, etc).\_\_\_\_\_ Yes/No**

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. **Does the applicant have a history of violence** (i.e.: verbal, physical, sexual issues)

Self \_\_\_\_\_ Others \_\_\_\_\_ Objects \_\_\_\_\_

If yes to any of the above please provide details.

a) Pattern and Circumstances: \_\_\_\_\_

\_\_\_\_\_

b) Most Recent Incident: \_\_\_\_\_

6. **Has the applicant had involvement with the legal/court system?** Yes/No

**If yes, please provide details** (e.g.: Pending charges, custody, court appearances, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

No Criminal Legal Problems		Awaiting Sentencing	
Pre-Charge Diversion		On Probation	
Court Diversion Program		On Parole	
Conditional Discharge		Incarcerated	
Fitness Assessment		Unknown or Service Recipient Declined	
Awaiting Trial/Bail			

7. **Does this individual smoke?** Yes/No

Does the applicant have a history of fire setting? \_\_\_\_\_ Yes/No

Careless smoking habits? \_\_\_\_\_ if yes to either, please provide details:

a) Pattern and Circumstance: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) Most Recent Incident: \_\_\_\_\_

\_\_\_\_\_

**8. Has there ever been a problem in any of the following areas:**

Check all that apply

Ailment	Specify Severity	Ailment	Specify Severity
Physical Illness		Speech	
Hearing		Depression	
Physical Handicap		Mood Swings	
Allergies		Diabetes	
Vision		Eating Disorder	
Epilepsy		Sleep Problems	
Developmental Delay			

Does this applicant have any medical conditions which could affect his/her participation in a community based housing program? Yes/No

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

Additional Comments/Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. Please Indicate History of Psychiatric Illness**

Date of Onset of First Illness: \_\_\_\_\_

Date of First Hospitalization: \_\_\_\_\_

Date of Most Recent Hospitalization: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

**Previous Psychiatric hospitalizations:**

HOSPITAL	DATE		LENGTH OF STAY
	Admit.	Discharge	

**Medications**

Medication:	Dosage:	Frequency:

Are there any concerns regarding medication use (e.g.: compliance)? \_\_\_\_\_

\_\_\_\_\_

**10. Skill Levels**

- 1) Needs a great deal of support with task.    3) Needs little support with task.  
 2) Needs some support with task.                4) Unknown.

Please use the above scale to indicate the individual's skill level in the following areas:

Skill/Task	Rating	Skill/Task	Rating
Menu Planning		Personal Hygiene	
Cooking		Grocery Shopping	
Banking/Budgeting		Social	
Household Cleaning		Laundry	
Utilization of Public Transportation		Use of Community Resources	

Any other pertinent information regarding daily living skills: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**11. Please indicate any noteworthy areas of difficulty this individual may be experiencing at the present time and the approaches utilized to alleviate the problems:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**12. Education**

Highest level completed: \_\_\_\_\_

Presently attending school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what program? \_\_\_\_\_

Future plans for further education? \_\_\_\_\_

**13. Work Experience**

Does applicant work now? \_\_\_\_\_

Previous or present employer: \_\_\_\_\_ Type of work: \_\_\_\_\_

Presently seeking employment? \_\_\_\_ If so, state type of work preferred: \_\_\_\_\_

\_\_\_\_\_

Volunteer experience (if applicable): \_\_\_\_\_

**14. Housing History** (For Housing applications only)

a) Has the individual lived in a Group Home or Supportive Housing Program? Yes/No

b) Can applicant live co-operatively with other people? Yes/No

c) Has the applicant lived in any of the following types of housing?

Shelter/Hostel/Emergency Housing/ Family Home/Independent Living	Please give a brief outline of clients experience

**15. Present Housing Needs:** (For Housing applications only)

Staff Support: High  Medium  Low

Preferred Geographical Area:

Burlington  Oakville  Milton  Georgetown  Acton

**Present Support Needs:** (Case Management applications only)

Burlington  Oakville  Milton  Georgetown  Acton

**16. Personal Goals**

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**OTHER**

In what areas do you think the Summit Housing & Outreach Programs Program can assist?

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**ADDITIONAL COMMENTS**

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The following documents (completed and signed) must accompany this completed referral form:

- |  | <u>Attached:</u> |
|--|------------------|
| <b>a) Disclosure of Personal Health Information Form</b><br>(Please note Halton Homes Program uses separate consent form for “Circle of Care”) | <b>Yes/No</b>    |
| <b>b) Disclosure of Criminal Record Information Form</b>   | <b>Yes/No</b>    |
| <b>c) Supporting documentation such as psychiatric summary, progress summary, clinical records, etc.</b>                                       | <b>Yes/No</b>    |

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