1201 JASPER DRIVE, SUITE A, THUNDER BAY, ON P7B 6R2
PHONE: (807) 343-0414 FAX: (807) 344-6140
WWW.HAGI.CA

APPLICATION FOR ACCESSIBLE HOUSNG, SUPPORTIVE HOUSING AND OUTREACH SERVICES

Program applying for:	✓	
Barrier Free Accessible Housing		Please fill out sections 1,2,3,4,6
Support Service Living Unit		Please fill out sections 1,2,3,5,6
Andras Court Cluster Units		Please fill out sections 1,2,3,5,6
Thunder Bay Outreach		Please fill out sections 1,2,3,5,6
Northshore Outreach		Please fill out sections 1,2,3,5,6

Section 1

Personal Information					
Name (Last Name, First Name)				Date of Birth (mm/dd/yy)	Sex ( )Male ( )Female
Permanent Address	City	Postal	Apt. #	Telephone Number:	
Temporary Address	City	Postal	Apt #	Telephone Number:	
Marital Status:				Primary Language:	
Social Insurance Number				Present Accommodations: ( ) Rent ( ) Own ( ) Co-own ( ) Temporary ( ) Hospital ( ) Home with family Other _____ _____ _ Rent $_____	
Status in Canada: ( ) Canadian Citizen ( ) Permanent Resident ( ) Refugee Claimant ( ) Metis Status ( ) Inuit ( ) Indian Status Band # _____					

Section 2

Please fill in the following information for the people who would be living in the unit (include children, if any). List yourself first. Income should include all sources (work, pensions, UIC, support payments, interest, social assistance).

Income					
Name	Age	Sex	Relationship to Applicant	Gross Income Per Year	Source of Income
			SELF		

Referring Individual (who is making the application):				
Name (Last Name, First Name)			Relationship:	Contact Person ( )Yes ( )No
Address:			Work Phone Number:	
City	Province.	Postal Code	Fax Number:	

Section 3

Support Network /Emergency Contacts				
Name (Last Name, First Name)			Relationship	Contact Person ( )Yes ( )No
Address:			Home Phone Number	
City	Province	Postal Code	Work Phone Number	
Name (Last Name, First Name)			Relationship	Contact Person ( ) Yes ( )No
Address:			Home Phone Number	
City	Province	Postal Code	Work Phone Number	

Education and Employment		
Name of Last School Attended:	Address of School:	
Level Attained:	Year Completed:	
Name of Last Employer:	Position:	How long were you there?

Leisure:
What do you enjoy doing in your spare time?

_____
_____

Reason for Application
Applicant:_____ _____ _____ _____ **Referring Individual :** _____ _____

Please list what other services you are currently receiving.

_____
_____
_____

Type of Accommodation Requested	Preferred Location	
( ) Bachelor	( ) Jasper	( ) Castlegreen
( ) 1 Bedroom	( ) Cumberland Court	( ) Superiorview
( ) 2 Bedroom	( ) Glenwood Court	( ) Andras (cluster)

Section 4

Accessibility	
I/ We require a unit with special accessibility options : ( ) Yes ( ) No Do you require a parking space? ( ) Yes ( ) No Pets? ( ) Yes ( ) No If so how many and what kind?_____ _____ _____	I/We require the following type of unit: ( ) Barrier Free (Internally modified for wheelchair) ( ) Other Accessibility (Walker, Braces, Etc) ( )Other Modifications (Hearing Impairment, Etc) Please Specify:_____ _____ _____ _____ _____ Can you climb stairs? ( ) Yes ( ) No

Section 5

Medical Information:	
Primary Disability	**Onset of Disability**
Secondary Disability	**Onset Of Disability**

Level of Personal Assistance			
Activity	**Independent**	**Some Assistance Required**	**Complete Assistance Required**
Skin Care			
Bathing			
Grooming			
Dressing/Undressing			
Bladder Management			
Bowel Management			
Exercises for mobility			
Meal Preparation			
Housekeeping			
Laundry			
Money Management			
Medical Appointments			
Shopping ,Grocery, Personal			
Other (please specify)			

Physical Status
Do you require a *wheelchair*? ( ) No ( ) **Yes, is it** - ( ) manual? ( ) motorized?
Do you require *other assistive devices*? ( )No ( )**Yes, please** state what is needed:
Can you transfer independently? ( )Yes ( )**No, please describe assistance needed**:_____
Are there any communication issues? ( )No ( )**Yes, please describe**:_____ _____
Any other physical conditions that should be mentioned? (allergies, heart conditions, diet restrictions, etc) ( )No ( )**Yes, please describe**: _____ _____

Medical Professionals: (e.g. General Practitioner, Specialist)			
Name	**Specialty**	**Address, Phone Number**	**Last Seen**

Medications:				
Name of Medication	**Dosage**	**Reason**	**Date Prescribed**	**Side Effects**

(Add additional pages if necessary)

Medication Administration - Self ( ) or ( ) Assistance required, specify what level_____

Section 6

References (Please list three other than relatives)		
Name	**Address**	**Telephone Number**

Signature of Applicant and /or Substitute Decision Maker:_____

Date of Appliction:_____