

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, ODSP, 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 2

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.

Section 3

Type of Accommodation Requested	Preferred Location/Program
<input type="checkbox"/> Bachelor <input type="checkbox"/> 1 Bedroom <input type="checkbox"/> 2 Bedroom	<p>Supportive Housing Thunder Bay Locations:</p> <input type="checkbox"/> Jasper 1201 Jasper Dr <input type="checkbox"/> Andras Court 122 S. Cumberland St <input type="checkbox"/> Glenwood 170 W. Donald St. <input type="checkbox"/> Castlegreen 150 Castlegreen Dr <input type="checkbox"/> Superiorview 110 Castlegreen <input type="checkbox"/> McKellar 325 Archibald St., 4 th Fl <input type="checkbox"/> Wilson 76 S. Cumberland St <p>Outreach Services</p> <input type="checkbox"/> Thunder Bay <input type="checkbox"/> Kenora <input type="checkbox"/> Northshore <input type="checkbox"/> Rainy River <input type="checkbox"/> Henesy Terrace 14 Woods Drive, Kenora <input type="checkbox"/> Riverview Manor Rainy River <input type="checkbox"/> Lady Francis 532 Front Street, Fort Frances
Accessibility	
<p>I/ We require a unit with special accessibility options :</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Do you require a parking space?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Pets?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If so how many and what kind? _____ _____ _____</p>	<p>I/We require the following type of unit:</p> <input type="checkbox"/> Barrier Free (Internally modified for wheelchair) <input type="checkbox"/> Other Accessibility (Walker, Braces, Etc) <input type="checkbox"/> Other Modifications (Hearing Impairment, Etc) <p>Please Specify: _____ _____ _____ _____</p> <p>Can you climb stairs?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4

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/Showers			
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 5

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

Your Signature and Authorization

By signing below, you agree that you understand the Privacy Policy, Disclaimer, Terms and Conditions and how your information will be used to process your application for services from CSI NW. You can read these items on our website at www.csinw.ca

I agree I have read and understand the above conditions for my application and how my personal health information will be used to determine my programs or service eligibility with CSI NW.

Signature of Applicant and /or Substitute Decision Maker: _____

Date of Application: _____

**Please return completed application to:
Community Services for Independence North West
1201 Jasper Drive, Suite A, Thunder Bay ON P7B 6R2
PHONE: (807) 343-0414
FAX: (807) 344-6140
EMAIL: info@csinw.ca**