KIOSAN HOUSING APPLICATION

Women Making Choices

Second Stage Housing Program

☐ Eligible ☐ Ineligible
☐ 1 Bedroom ☐ 2 Bedroom
☐ Studio (Note: Studios are furnished units.)

Name: _____

Address: _____

_____Email: _____

Phone: _____Is it safe: to call? ☐ **Y** ☐ **N** leave msg? ☐ **Y** ☐ **N**

send text msg? ☐ **Y** ☐ **N**

Emergency Contact: _____

Relationship: _____ Address: _____

_____

Phone: _____Is it safe: to call? ☐ **Y** ☐ **N** leave msg? ☐ **Y** ☐ **N**

send text msg? ☐ **Y** ☐ **N**

Provide the following for all persons in housing request (*including applicant*):

First Name	Last Name	Age	Gender	DOB DD/MM/YYYY

P.O. Box 6206 Picton Ontario, KOK 2TO
Crisis Line · 613-476-2787
Toll Free 1-877-499-6636
Admin: 613-476-4435
www.alternativesforwomen.ca

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Abuser Information

Abuser Name: _____ Relationship: _____

DOB: _____ Age: _____ Address: _____

_____

Description: Height_____ Weight: _____ Eyes: _____ Hair: _____

Distinguishing Marks:_____

Work:_____ Vehicle: _____

Color: _____License: _____

Abuse Issues

Have you left an abusive relationship? ☐ **Y** ☐ **N**

Was there police involvement? ☐ **Y** ☐ **N**

Were charges laid? ☐ **Y** ☐ **N**

Is there a restraining order/peace bond in place? ☐ **Y** ☐ **N**

When was the last form of contact made by your abuser?

_____

Abuse type experienced: ☐ Physical ☐ Emotional ☐ Verbal

☐ Psychological ☐ Financial ☐ Sexual ☐ Spiritual

Additional concerns: _____

_____

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Vehicle

Do you have a vehicle? ☐ **Y** ☐ **N** If yes, please provide the following:

Colour _____ Make _____

Model_____ Licence Plate No._____

Pets

Do you have pets? ☐ **Y** ☐ **N** If yes, please describe: _____

_____ Are they spayed or neutered? ☐ **Y** ☐ **N**

Are all shots up-to-date? ☐ **Y** ☐ **N** (*paperwork required*)

Income Information

Employment	☐ Y ☐ N	$_____	per month (net)
Ontario Works	☐ Y ☐ N	$_____	per month
Employment Insurance	☐ Y ☐ N	$_____	per month
ODSP	☐ Y ☐ N	$_____	per month
Support Payments	☐ Y ☐ N	$_____	per month
Other (specify)_____	☐ Y ☐ N	$_____	per month
Total Income from all Sources		$_____	per month

Do you or any of your live-in family members have any special needs?

☐ **Y** ☐ **N**

If yes, please give details:

_____

Do you have a family doctor? ☐ **Y** ☐ **N**

Do you or any of your live-in family members require, or receive, home supports services? ☐ **Y** ☐ **N** If yes, please give details:

_____

_____

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Health Information

Referral Source:

- ☐ Self
- ☐ Friend/Family
- ☐ Canadian Mental Health Assoc.
- ☐ Crisis Intervention Centre
- ☐ Hospital
- ☐ Mental Health Services
- ☐ Ontario Works, ODSP
- ☐ Other (specify)_____

Involvement with other supports and services:

- ☐ Mental Health Services
- ☐ Addiction Services
- ☐ ACCT Team
- ☐ Children's Aid Society
- ☐ Psychiatrist
- ☐ Family Doctor
- ☐ Food Bank
- ☐ Ontario Works
- ☐ ODSP
- ☐ Crisis Intervention Team
- ☐ Other (specify) _____

Have you been to the doctor in the last 30 days? ☐ Y ☐ N If yes, why?

_____

_____

Have you been to the hospital in the last 30 days? ☐ Y ☐ N If yes, why?

_____

_____

Do you take medications?

☐ Y ☐ N Please list medications:

_____

_____

Are you taking your medication(s) regularly?

☐ Y ☐ N ☐ N/A

If no, why? _____

_____

To the best of my knowledge the information provided in this form is true and correct. I understand this application will be reviewed for eligibility and I will be placed on a wait list. I also understand that it is my responsibility to maintain contact and provide current application information.

Signature Date

Witness Signature Date

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