



COMMUNITY HOMES FOR OPPORTUNITY (CHO) Application Form

COMMUNITY HOMES FOR OPPORTUNITY (CHO) assists individuals over the age of 18 living with serious mental illness by providing stable, affordable, appropriate housing and support services. CHO aims to support individuals to achieve and maintain physical, mental health, and wellbeing, as well as foster independence and enhance participation and integration into the community of their choice. CHO is a person-centred, flexible service, reflecting the individual and their changing needs. CHO strives to promote active participation in their own planning and ensuring the opportunity to make individual choices. The following services will be provided:

1. Stable Accommodation: 24 hour supported living environment within a congregate setting.
2. In-home support including activities of daily living, meals, and medication support.
3. Individualized multidisciplinary plans of care and community integration planning may include the following;
 - a. Development of living skills
 - b. Case Management and clinical support, in collaboration with other providers as required
 - c. Develop abilities in the areas of living including recreational and leisure activities; employment, education, health monitoring, etc.;
4. Community crisis planning and support.

HOW TO APPLY

- ✓ Complete ELIGIBILITY, COMMITMENTS, SECTIONS A TO I, SUPPORT CONSIDERATIONS and CONSENT (all area of the application must be completed otherwise application could be denied)
- ✓ FAX (705-645-7473); Attention to CHO

QUESTIONS? EMAIL CHO@cmhamps.ca – CHO Case Manager, 705-645-2262

- ✓ MAIL (CMHAMPS, 173-202, Manitoba Street, Bracebridge, Ontario, P1L 1S3; Attention to CHO)

ELIGIBILITY (Please ensure all the boxes are checked in this area or application may be rejected).

- Living with a chronic and long-term mental health condition, impacting the person's ability to perform day to day activities and the inability to live independently even when support is provided. Primary areas of need are not related to a developmental or intellectual disability.
- Psychiatrically stable with a demonstrated adherence to treatment plans.
- Ability to reside in a supported congregate living setting with multiple roommates of varying ages and abilities.
- Medically stable, and if experiencing ongoing or complex physical health issues, appropriate home-based health support is or will be in place (e.g., Home & Community Care, Personal Support Workers, Private Nursing, etc.).
- Able to take direction from others in an emergency situation.
- Able to navigate stairs independently.
- Able to complete ADLs independently with prompting
- Able to provide financial documentation proving source(s) of income.
- Able to pay their portion of the rent/living expenses.

COMMITMENTS

The Applicant has demonstrated abilities and behaviours that will allow them to successfully commit to the following:

- Engaging in activities of daily living and personal responsibilities for living within congregate/shared home environment and achievement of individual recovery goals.
- A living environment that is free from violence, aggression, intimidation, harassment, and other behaviors that present harm or risk of harm to other residents, staff, and the physical environment of the home.
- A positive, healthy, safe, and respectful living environment.
- An alcohol and drug free living environment.
- A fire hazard free home.
- A smoke free living environment: Smoking is permitted outside of the home in a designated area.

A. GENERAL INFORMATION	TREAT MRN:
NAME: DATE OF BIRTH (dd/mm/yy): HEALTH CARD # (include Version Code): GENDER IDENTITY and/or PRONOUNS: Decline <input type="checkbox"/> CURRENT ADDRESS (including mailing address) PHONE NUMBER:	
RELATIONSHIP STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Partner/Significant Other <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Declined	
Indigenous Status: Indigenous <input type="checkbox"/> Non- Indigenous <input type="checkbox"/> Unknown/Declined <input type="checkbox"/>	
Preferred language: <input type="checkbox"/> French <input type="checkbox"/> English <input type="checkbox"/> Other (please specify):	
B. SUBSTITUTE DECISION MAKER: <i>Provide relevant documentation/details if available.</i>	
SDM for Finances-Property: Name: Contact #: Comments:	
SDM for Treatment Decisions: Name: Contact #: Comments:	
Trustee (Details): Power of Attorney (Details): Other (Details):	
C. FAMILY or SIGNIFICANT OTHERS: <i>Only provide the name/phone number for those you allow us to contact and speak with about your application to CHO.</i>	
Name/Relationship Contact Details	
Name/Relationship Contact Details	
Name/Relationship Contact Details	

D. PSYCHIATRIC & MEDICAL HEALTH HISTORY

Provide supporting documentation (e.g., discharge summaries, psychiatry assessments, etc.)

Psychiatrist:

Phone #:

Family Physician:

Phone #:

Pharmacy:

Phone #:

Psychiatric Diagnoses:

Medical Diagnoses:

Other Disabilities/Conditions that may affect service delivery

Medications (if yes, please attached a medication list separately): Y N

Last Medication review: ____/____/____
 DD MM YYYY

Presentation *(A description of their mood, affect, thought process/content, verbal and behavioural expressions or other indicators that are typical for them when they are not experiencing an escalation or risk or crisis.)*

Risk Presentation *(Indicators relating to mood, affect, thought process/content, verbal, and behavioural expressions; voiced intent or other indicators that inform they are at risk or becoming at risk.)*

History of Harm to Self or Others:

Recommendations *(Informed directions on how best to support when experiencing acute crisis situation, or how to support them with preventative measures prior to a crisis escalation.)*

Psychiatric Admission History (in the last 2 years)		None <input type="checkbox"/>	
Name and Location of Hospital	Dates (mm/yyyy)	Length of Stay	Reason for Admission
1.			
2.			
3.			

Number of visits to the emergency room, for mental health or addiction reasons, in the past 6 months?

Is there a Current Community Treatment Order? Y N
 If yes, please attached a copy of the CTO and CTP.

Hospitalizations for medical reasons in the last 2 years? Y N

Name and Location of Hospital	Dates (mm/yyyy)	Length of Stay	Reason for Admission
1.			
2.			
3.			

E. HOUSING HISTORY
Provide details of living situations over the past 5 years to present day.

F. LEGAL STATUS

Past Legal Issues? Y <input type="checkbox"/> N <input type="checkbox"/>	Details
Current Legal Issues? Y <input type="checkbox"/> N <input type="checkbox"/>	
ORB community access/conditional discharge? Y <input type="checkbox"/> N <input type="checkbox"/>	
Probation: Y <input type="checkbox"/> N <input type="checkbox"/> Parole: Y <input type="checkbox"/> N <input type="checkbox"/>	

G. INCOME: *Declare all sources of income and gross monthly income before deductions and provide supporting documentation (Notice of Assessment – Line 150 Required)*

ONTARIO DISABILITY SUPPORT PLAN (ODSP):
 Member ID Number:

CANADIAN PENSION PLAN (CPP):

WSIB / PRIVATE INSURANCE:

OTHER SOURCES OF INCOME:

ESTIMATED TOTAL ANNUAL INCOME:	
Other Relevant Financial Details (e.g., bank statement, etc.)	
H. SERVICES AND SUPPORTS: State all services and support <u>currently received</u>. Include name, contact details, and what help they provide you.	
I. AREAS OF NEED	
Not Required: Person addresses need without support Minimal Support: Can live independently with support to address need Intensive Support: Requires supported congregate setting to address need	
Information on Condition & Treatment: Needs associated with the person receiving and understanding information about their physical and mental health conditions and treatment. Includes needs associated with competency and capacity for decision making, consent, and substitute decision making.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Safety to Self: Needs associated with the person being a danger to him-herself; having thoughts of and risks associated to suicide or non-accidental self-injury. Includes behavioral risks such as recklessness, impulsivity, carelessness, wandering, and other risk-taking activities.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Safety to Others: Needs associated with the person being a danger or risk to other people; having a history of violence or threatening behaviours; engaging in behaviours that place other people at risk of being harmed; overactive; aggressive disruptive behaviours.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Safety From Others: Needs associated with risks the person experiences from other people such as assault, victimization, exploitation, human trafficking, etc.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Risk Management: Activities focusing on the management of risk related circumstances and/or needs including but not limited to risk assessments, crisis prevention, crisis management guidelines.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Psychotic Symptoms: Needs and risks associated with symptoms of psychosis and psychotic features including treatment, and related interventions and supports.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Psychological Distress: Needs associated with the person suffering from psychological distress, receiving, or not receiving sufficient support, and risks associated with psychological distress. Includes needs and risks associated with clinical features, for example, depression, anxiety, mania, emotional instability and dysregulation, obsessions/compulsions, phobias, etc.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Trauma: Needs associated in any area of life for a person suffering from a traumatic event(s) of any kind that affects their daily living or who experiences serious barriers to wellness and recovery as a result of a traumatic event(s) of any kind.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Physical Health: Needs associated with the person's physical health, physical health conditions, the requirement for treatment of physical ailments, untreated physical ailments, side effects to medications, etc. Needs associated with the person's ability to self-manage their physical health needs and conditions such as diabetes, colostomy care, medications, etc.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Alcohol: Needs associated with excessive consumption of alcohol, or problems controlling their alcohol intake. Is drinking resulting in harmful effects or loss of control of use, or does the person require help for alcohol use? Is drinking resulting in harm to others?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Drugs: Needs associated with the consumption of drugs, and dependence on prescribed, non-prescribed or illegal drugs including any negative or harmful effects that this use has for the person or other people. Does the person require help for drug use?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Other Addictions: Needs associated with behavioral/process addictions such as pornography, sex, shopping, or problems controlling these behaviours. Are these behaviours causing any harmful effects on the person or other people, their quality of life, or does the person require help for these behaviours?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support

Gambling: Needs associated with behaviours and outcomes of gambling. Is gambling causing any harmful effects on the person or other people, their quality of life, or does the person require help for these gambling?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
RAAM: Needs associated with alcohol or drug abuse and the person requires rapid assessment and treatment services including medication-assisted treatment and withdrawal management.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Cultural/Spiritual: Mental, emotional, spiritual, cultural, and physical needs strengthened through both traditional and cultural healing, health and wellness practices.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Wellness/Recovery: Needs associated with a person's journey moving through stages of recovery from mental illness, addiction, or other health condition. The person is learning, understanding, and applying new values, abilities, skills, and experiences in the process of discovering/rediscovering a positive sense of self, satisfying and meaningful life experiences, and regaining autonomy within one's life separate from the presence or absence of diagnosis or symptoms.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Peer Support: A structured relationship where a person is living with mental illness, addiction or other health condition and engages in an active process of commonality of experience, mentoring within the recovery process, rights-based advocacy, learning/sharing with a 'specialist' who has lived experience and applies their personal experiences for the sole therapeutic benefit the person. The primary focus being recovery and rehabilitation the relationship is guided by the values of hope, recovery, self-determination, empathetic and equal relationships, dignity, respect, and social inclusion.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Outreach/Engagement: Needs and actions associated with encouraging the person to identify the benefits of mental health/addiction supports and engage with formal support systems and services. The process of building a therapeutic alliance between the person and the service provider.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Company: Needs associated with the person's ability to organize, engage, and participate in social, family, friendship contacts. Is the person feeling lonely and isolated? Have they withdrawn from normal social groups and social activities?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Intimate Relationships: Needs associated with the person's ability to find, secure, and maintain a partner or close relationship(s). Is the person at risk within a current relationship or identifies a need for a close relationship? Needs or risks associated with social breakdown or conflict within intimate relationships.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Family/Parenting: The person is experiencing needs/risks associated with relationships and dynamics within their immediate family or with significant others within their immediate "family circle", needs/risks associated with their parenting role, or needs/risks associated with their biological family/family of origin.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Sexual Expression: Needs associated with the person's sexual life? Is the person satisfied with their sexual life? Is the person engaging in sexually risky behaviours or has serious sexual difficulties? Is the person's sexual expression or behaviours harmful to them or other people?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Child Care: Needs associated with the person having difficulty looking after their child (or a dependent child). Is the person able to parent their child or is the person experiencing serious difficulties parenting? Is the dependent child at risk of harm? Is/should CAS be involved?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Other Dependents: Needs associated with the person having difficulty caring for/being responsible for a pet, loved one, or another individual who is dependent on the person. Is the person able to provide the care required or is the person experiencing serious difficulties in providing this care? Is the other dependent at risk of harm?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Accommodation: Needs associated with adequate levels of housing, homelessness, precariously housed, or home lacking basic facilities such as water, electricity, heat, etc.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Looking after the home: Needs associated with the person's ability to look after their home, home maintenance, keeping the home clean and safe, potential risks associated with an unkempt environment. Does the person require help to maintain their home?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Food: Needs associated with the person's ability to buy and prepare meals, dietary restrictions, maintain available and appropriate food. Does the personal have enough to eat?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Self-Care: Needs associated with the person ability to complete basic activities of daily living such as dressing, toileting, hygiene, eating, etc. Needs associated with person's ability to keep themselves clean and maintain hygiene that does not place them at medical or social risk.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support

Daytime Activities: Needs associated with the person’s ability to located, engage, and participate in meaningful daytime activities and social activities. Includes needs associated with employment or loss of employment, volunteering, clubs, social groups, social withdrawal, or avoidance from normal activities, etc.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Education: Does the person lack basic skills in numeracy and/or literacy? Does the person have serious difficulties reading, writing, and understanding English/French? Do they require or receive help to read, write, understand, or complete numerical processes? Does the personal have needs associated with school, education, failing at school, dropping out of school, etc.?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Legal Issues: Is the person involved in the legal justice system or legal proceedings? Does the person require help associated with court diversion, probation/parole, family court, civil proceedings, police involvement, retraining orders, no trespass orders, provincial offences, etc.?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Communications: Does the person have difficulty getting access to, or using a telephone, cell phone, or communication device? Does the person lack access to the internet? Can the person use their means of communication? Is the person dependent on someone else for remote communication? Does the lack of access present serious challenges to the person?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Transportation: Needs associated with not having access to methods of transportation, or barriers that interfere with accessing methods of transportation. Does the person experience serious challenges associated with the lack of transportation? Is the lack of transportation resulting in social isolation or interfering with the person getting their needs met?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Money: Does the person have problems with budgeting and money management? Needs associated with ineffective money management and budgeting. Does the person require help with money management and budgeting?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Benefits: Is the person receiving all of the benefits they are entitled to (i.e., ODSP, Drug coverage, special allowances, rent subsidy, etc.). Is the person experiencing difficulties associated with not receiving sufficient benefits? Does the person require help to access benefits?	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support
Physical Activity: The promotion of wellness and health through physical activity and recreation.	<input type="checkbox"/> Not Required <input type="checkbox"/> Minimal Support <input type="checkbox"/> Intensive Support

SUPPORT CONSIDERATIONS (*Individual’s self-report*):

“WHAT IS IMPORTANT TO ME”

“WHAT PEOPLE NEED TO KNOW TO SUPPORT ME”

“WHAT PEOPLE NEED TO DO TO SUPPORT ME”

“WHAT I DON'T WANT PEOPLE TO DO TO ME”

IS THE APPLICANT (AND SDM IF APPLICABLE) CONSENTING TO THIS APPLICATION?

DOES THE APPLICANT (AND SDM IF APPLICABLE) CONSENT TO THE SHARING OF THIS INFORMATION WITH CMHAMPS FOR THE PURPOSE OF THIS APPLICATION TO CHO?

Yes: _____
Signature of Applicant/SDM *Date*

No: _____ Application will not be considered.

**Any additional information available regarding the applicant will be appreciated.
Please attach any completed Consents to Release Personal Health Information forms.**

What service provider will support the applicant until a vacancy becomes available?

Who is the primary contact while the applicant is on the wait list?

Referral Source: _____

Referral Contact Information: _____

Referral Completed By / Signature: _____

Date: _____