Portable Housing Benefit Referral

PERSONAL INFORMATION

Client's Name: ________________________________

Sex: _________________________

Date of Birth____________________

Phone#: ________________

PROVIDER INFORMATION

Referral Source: __________________________

Phone#: ________________________________

Name: ___________________________

Email:__________________________

Organization: ________________________________

EIA worker___________________________

File number: __________

HOUSING INFORMATION

Current Address: _____________________

Length of Tenancy:______

Client is PRESENTLY residing in: (select one) o Apartment o Homeless o House
o Hotel o Rooming House o Parents/Family
o Hospital/CSU o Emergency Shelter o Group
o Home/Residential Care

Reason for Applying for PHB:

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Previous Address: ____

Previous Landlord: ____

How long at former address: ______________________________________

Current Rent____________ Previous Rent Amount: $_______________

Client' s **PREVIOUS** Housing Situation: (please select one)
o Apartment o Homeless o House Hospital/CSU o Emergency Shelter o Group Home/Residential Care
o Hotel o Rooming House o Parents/Family

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GENERAL INFORMATION

1. What problems does client have with present housing?

2. What services and/or supports is client receiving? (Provide Details)

3. Is substance use currently a problem? o No o Yes (Explain)

4. What service goals have been established with client in past twelve months? What has been achieved?

5. What barriers is the client facing relating to their recovery?

INSTRUCTIONS

Please check all that apply for client.

NOTE: For the 5 factors with an asterisk (*) please identify the number of times in the space provided after the asterisk.

Criteria 1-Program Eligibility

o Presently enrolled on EIA as a person with a mental health disability

Criteria 2-Better Service Outcomes

Expect increased clinical/functional improvements as a result with better housing and/or affordable rent

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Expect increased engagement in service (s) with better housing and/or affordable rent

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Lack of Adequate and Affordable Housing (check all that apply)

o Presently homeless or "couch surfing"
o Living with family in an unstable situation
o Poor quality housing
o Unsafe housing
o Client has experienced moves in the past 12 months *_ _
o Client has experienced evictions in the past 12 months *_ _
o Displaced by hotel, room & board or other housing in the past 12 months
o At risk of losing housing

Criteria 3-Specialized Housing/Service Needs

o Requires different housing type or neighborhood due to complex clinical/functional issues:

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+______

Requires accessible/specialized housing because of disability and medical conditions Explain: ____

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ADDITIONAL COMMENTS ____

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Referral Signature ______________________

I understand and agree that the screening committee may contact the referral service for more information to support my application as well as contact my financial worker to verify my financial information and mailing address.

I understand that if approved for the Portable Housing Benefit some information about me may be shared with Landlords/Caretakers for the purpose of securing housing. I agree to meet with my Housing Support Worker regularly while receiving the Portable Housing Benefit.

Date: ______________________________

Client Signature: ______________________

PLEASE SUBMIT THE COMPLETED REFERRAL APPLICATION TO:

c/o Canadian Mental Health Association Dauphin Office

Terra Matthews 135 1st AVE SW R7N 1S1 or fax to 204-701-0159
For questions call: 204-701-0153

For Office Use Only:

Approved for PHB: o Yes o No

Referral Source and o Yes o No

Housing Secured o Yes o No