|  |
| --- |
| This referral form is used to recommend a person to receive transition housing supports from the Mainstay Residence. After this referral form is received, the individual or referring source will be contacted to arrange an in-person interview. Following the interview, the individual will be recommended to the eligibility list of the Mainstay Residence. |

**Application Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Person #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Currently accessing other MSP programs:** 🞎 Shelter 🞎 IPDA 🞎 Detox 🞎 Transition Team

|  |  |  |
| --- | --- | --- |
| **BASIC INFORMATION:** | | |
| *First Name:* | *Last Name:* | *Alias:* |
| Date of Birth: | Gender: 🞎 M 🞎 F 🞎 T | SIN #: |
| MB Medical: *9 digit* | *6 digit* |  |
| Band Name: | Band #: | Treaty #: |
| Current Address: | | Phone #: |
| Marital Status: 🞎 Single 🞎 Married 🞎 Common-Law 🞎 Divorced 🞎 Separated 🞎 Widowed | | |
| Languages Spoken: | | |

|  |  |
| --- | --- |
| **EMERGENCY CONTACT INFORMATION** | |
| **Name:** | **Relationship:** |
| **Phone:** | **Address:** |

|  |
| --- |
| **SOURCE OF INCOME:** |
| 🞎 Full-Time Employment 🞎 Part-Time Employment 🞎 Casual Employment 🞎 Other: |
| 🞎 EIA (confirmed active unemployment/disability)  EIA Case #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coverage Type: 🞎 GA 🞎 Disability  Case Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Employment Insurance Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Pension (CPP) |
| 🞎 Unemployed |
| 🞎 Public Trustee Name of Trustee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 No funding / Awaiting confirmation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **CURRENT HOUSING NEEDS:** |
| **Current Living Situation:** 🞎 No Risk 🞎 At Risk/Not Immanent 🞎 At Risk/Immanent Risk 🞎 Currently Homeless  🞎 Hidden Homelessness 🞎 Living on Streets 🞎Crisis Shelter 🞎 Transitional Housing 🞎 Supportive Housing  🞎 Treatment Centre 🞎 Discharged from Hospital 🞎 Discharged from Jail 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Length of Current Living Situation:** 🞎 Short-term 🞎 Long-term 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What is the primary issue that makes it difficult for this individual to maintain** |
| **Subsidized Housing History**: 🞎 Yes 🞎 No (explain history)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Taxes up to date:** 🞎 Yes 🞎 No |

|  |
| --- |
| **COMMUNITY AND SOCIAL SUPPORTS** |

*Mental health worker, home care nurse, community support programs*

|  |  |  |
| --- | --- | --- |
| Name: | Program: | Phone: |
| Location: | | After Hours Emergency #: |
| Name: | Program: | Phone: |
| Location: | | After Hours Emergency #: |
| Name: | Program: | Phone: |
| Location: | | After Hours Emergency #: |
| **Currently restricted from any community programs?** 🞎 Yes 🞎 No  *If yes, please explain:* | | |

|  |  |
| --- | --- |
| **ADDICTION:** | |
| **Drug Use** (illegal / prescription)🞎 Yes 🞎 No  If yes, please check all that apply:  🞎 Cocaine 🞎 Crack 🞎 Weed 🞎 Oxy 🞎 Heroin 🞎 Meth 🞎 Demerol 🞎 Codeine 🞎 Ecstasy 🞎 Opiates  🞎 Benzo’s 🞎 Pills 🞎 Ritalin 🞎 Solvents 🞎 Prescription mis-use 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Alcohol Abuse:** 🞎 Yes 🞎 No | **Gambling Issues:** 🞎 Yes 🞎 No |

|  |
| --- |
| **MEDICAL INFORMATION:** |
| Health Conditions: 🞎 Yes 🞎 No (such as diabetes, asthma, hypertension, etc)  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you require an accessible suite?: 🞎 Yes 🞎 No  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you require Homecare Services?: 🞎 Yes 🞎 No (laundry, bathing, transferring, dressing)  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has a referral been made? 🞎 Yes 🞎 No |
| **Doctor:** 🞎 Yes 🞎 No Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: \_\_\_ Phone: \_\_\_ \_\_\_\_\_\_\_\_  Location: |

|  |
| --- |
| **MENTAL HEALTH** |
| Self-harm : 🞎 Yes 🞎 No Last occurrence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Harm towards others: 🞎 Yes 🞎 No  *If yes, please explain (verbal, physical, sexual, patterns, circumstances, self, others):*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hallucinations / Delusions: 🞎 Yes 🞎 No Last Occurrence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If yes, please explain*:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mental Health Connections:  Psychiatrist / Counsellors Name: \_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **JUDICIAL INVOLVEMENT:** |
| Involvement with the legal / court systems: 🞎 Yes 🞎 No 🞎 N/A  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pending charges: 🞎 Yes 🞎 No Coming Court Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Restraining Order / Peace Bond: 🞎 Yes 🞎 No  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Probation / Parole: 🞎 Yes 🞎 No 🞎 N/A  *If yes, please explain*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  P/O Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coming Court Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Consent for Release of Confidential/Personal Information/Photo Identification**

****

**Client Name:**

|  |  |  |
| --- | --- | --- |
| **Date of Birth***: (D/M/Y)* | **AGE:** | **Health Card # :** |
|  |  | **PHIN** *#:* |
|  |  |  |

**I hereby authorize Main Street Project (MSP), to release and/or obtain information from the following agencies/persons listed below, as well as those that I have added under “other” herewith:**

|  |  |
| --- | --- |
| Paramedics (WFPS), as it pertains to my care | Crisis Unit, Mobile Crisis Unit, as it pertains to my care |
|  |  |
| Addiction Treatment Programs, as it pertains to my care | Other Agencies as it pertains to my care |
|  |  |
| Employment and Income Assistance (Welfare) | Other funding source if applicable / Public Trustee |
|  |  |
| Medical professionals involved in my care | WRHA |
|  |  |
| Hospital staff as it pertains to my care | Broadway Pharmacy (or other Pharmacy) |
|  |  |
| Housing/Landlord as it pertains to my care | Parole/Justice/Lawyer (if applicable) |
|  |  |
| Spouse/Partner/Parent: | Emergency Contact (as listed on my application form) |
|  |  |
| CHAT | All Main Street Staff, including Transition Services |

*\*I have crossed out and initialed any agency/person that I do not give my consent to share information with that is listed above.*

**Other:** (list anyone that is not already listed above that we may need to speak with on your behalf)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA), I authorize Main Street Project to disclose my Medical Clearance Form and/or the following Personal Health information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to the agencies listed above for the purpose of my treatment planning goals.

I recognize that information may be shared, as required, with other team members and programs within Main Street Project. In addition, confidential information will be shared without written consent if child abuse is suspected, records are subpoenaed, or clients are felt to be a threat to their own or another individual’s health and/or safety.

I hereby waive any and all claims against Main Street Project, employees and agents for all purposes whatsoever arising from the disclosure of this information.

I understand and agree to have my picture taken for the purpose of identification within MSP and its partnering agencies

**I acknowledge that this consent form has been explained to/read to me by an authorized MSP staff member and that I had the opportunity to ask any questions or remove the consent for anyone listed on this document. I understand that this consent may be withdrawn or modified at any time by providing notice in writing.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Management Services Referral and Consent Form Case Management Administrative Coordinator 661 Main Street, Winnipeg, Manitoba R3B 1A4 T: 204-982-8795 F: 204-943-9474**



# Part 1: Personal Information *(Please Print)* PLEASE ANSWER AS COMPLETELY AS POSSIBLE

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where can we contact you or leave a message for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any community workers, resources or programs you are currently using:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Source:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homeless Outreach Mentor (HOM) Description**: *Offers Outreach, Housing Supports, and Stability to Community members experiencing chronic, episodic, temporary, and imminent homelessness.*

**General Case Management Services Description:** *Offers the opportunity to connect with a Case Worker to support the client to identify goals and work on immediate needs. Case Workers will work collaboratively with other agencies to best serve the needs of the client.*

**Project Breakaway Description:** *Project Breakaway Provides housing, community supports and intensive case management services to community members experiencing homelessness and who frequently use two or more emergency services.*

Please select the type of Case Management services you are referring to:



HOM General Case Management Project Breakaway

Members of the Project Breakaway Committee include:

* EIA - MSP Paramedics - Winnipeg Police - Siloam Mission
* WRHA - City of Winnipeg - Main Street Project - Salvation Army
* CHAT Team - Doorways

What is your current living situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current source of income? (EIA/EI, OAS, CPP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on Pension/OAS? Yes No

Do you need help getting identification? Yes No

If Yes: Which ID’s:

**Part 2: Housing**

Do you have a housing history with Manitoba Housing Winnipeg Housing or subsidized housing? Yes No

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been evicted? Yes No

What type of housing are you currently seeking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a security deposit/or are you eligible through EIA for a security?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the only person that will be living at the residence? Are there going to be others such as family, partners, or roommates moving in with you, who are signing the lease, and who will be contributing towards rent?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know what your credit rating is? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Furnished or unfurnished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had involvement with the Residential Tenancies Branch?

**Are you willing to meet with your case worker at MSP at least twice a week? YES NO**

**Part 3: Consent**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my consent for the purpose of the selection process for Case Management Services. I recognize that information may be shared, as required, with other team members and programs within Main Street Project. In addition, confidential information will be shared without written consent if child abuse is suspected, records are subpoenaed, or clients are felt to be a threat to their own or another individual’s health and/or safety. This consent is valid for one year from the date of submission. I understand that this consent may be withdrawn or amended at any time. I understand that for Project Breakaway consideration, I am consenting to the above partners to discuss my systems usage for the purposes of determining my eligibility for Project Breakaway Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Person Consenting Signature of Agency Staff Requesting Consent Date