



**ABBAY HOUSE**  
HEALING BEGINS AT ABBAY HOUSE



## Intake

Applicant Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referred by: (Agency) \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

### Native Status

Status    Non-Status            Metis            Bill C-31            Unknown

### Marital Status

Single    Common Law    Married    Separated    Divorced    Widowed

### Children:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex F/M    School Grade \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex F/M    School Grade \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex F/M    School Grade \_\_\_\_\_

(If necessary, list on the back of this sheet)

**Are there any children not in your care or who will not be residents?**

**Where are you presently living?**

House /Apartment    Temporarily with family/friends  
Hotel /Motel    Other

Ce projet est financé par  
l'Initiative nationale pour les sans-abri  
du gouvernement du Canada.

**Canada**



**Do you consider yourself one of the following?**

(Abbey House is second stage housing after stay at Domestic Violence Shelter)

Are there any safety issues/concerns regarding current or past personal relationships?

Restraining orders    Peace Bonds    Custody orders CAS conditions    Other

If so please explain, received and expires:

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**Risk of Abuser**

Explain: \_\_\_\_\_

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Description of abuser (If necessary provide photo)

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**What other agencies/service providers are you currently involved with?**

Mental Health Services	Probation & Parole	F.A.C.S
Public Health Services	Counseling	Legal Services
Addictions Services	Employment Services	

Other \_\_\_\_\_



**Accommodation History:**

Yes      No

If yes, please complete the following section

<u>Name of Establishment</u>	<u>Month/Year</u>	<u>Length of Stay</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

How long did you reside at this address? \_\_\_\_\_

Do you currently have a lease?      Yes      No

If yes is your lease yearly or monthly? \_\_\_\_\_

When does your lease expire? \_\_\_\_\_

What is the total cost of your current accommodations? \_\_\_\_\_

Describe the reasons or events for you currently needing residential assistance/support:

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

What do you feel needs to happen or change for you to overcome your current situation?

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



Would you like to learn more about any of the following programs offered?

Financial Skills  
Employment

Social Skills  
Physical health

Life Skills    Education Upgrade  
Cultural awareness

Other

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Explain the life changes you would like to happen during your stay in this transitional home.

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What makes up your support system, or can you express your needs? ( i.e. childcare, transportation, emotional support)

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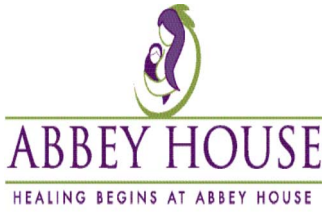
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**Education Background/Goals:**

[Diploma] \_\_\_\_\_ GED \_\_\_\_\_  
College [Diploma] \_\_\_\_\_  
University [Degree] \_\_\_\_\_  
Technical/trade [Certificate] \_\_\_\_\_  
Special training/Skills? \_\_\_\_\_

Yes  No

Yes  No

Do you currently attend school?  Yes  No

Name of School: \_\_\_\_\_

Address of School: \_\_\_\_\_

Contact person at school:

\_\_\_\_\_

Telephone

# \_\_\_\_\_

\_\_\_\_\_

Do you attend:  Part-Time  Full-Time

Last Grade completed \_\_\_\_\_

**EMPLOYMENT:**



Describe your job interests or career goal \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Health**

Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Health Card # \_\_\_\_\_

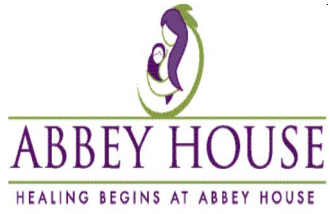
**Personal Health Conditions:** (Check if yes)

Allergies:	Food	Environment	Medicine
Identify:	_____		
Diabetes	Type 1	Type II	
Thyroid	Hyperthyroidism	Hypothyroidism	
Heart Condition:	Identify _____		
Blood Pressure	(High) Hypertension	Low	
Arthritis:	Osteoarthritis	Rheumatoid	Fibromyalgia
Respiratory problems			
Epilepsy			
Cancer			
Communicable diseases:	Identify _____		
Physical Disabilities:	Identify _____		
Mental Illness:	Identify _____		
Substance use:	Chemical	Alcohol	
Identify:	_____		
How many days have you been clean?	_____		
What was your age of first use?	_____		
Are you currently pregnant?	_____	If yes, how many weeks?	_____
Other (Please specify)	_____		

**Are you and your children's immunization up to date?**

**Please list any medications you have been prescribed or are taking(Dates):**

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



**Children/Youth Health (complete for each child staying in transitional housing)**



**Financial Information**

**Income Source**

*If yes, when, where, and how much?*

\_\_\_\_\_

\_\_\_\_\_

Hydro \$ \_\_\_\_\_  
Water \$ \_\_\_\_\_  
Oil/Propane \$ \_\_\_\_\_

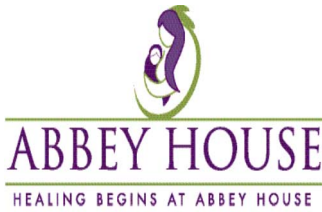
Telephone  
Land Line \$ \_\_\_\_\_  
Cell \$ \_\_\_\_\_

Yes No

The applicant certifies that all information in the Income? Expense Information Form and all information furnished in support of this statement are true and complete to the best of the applicant's knowledge and belief.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



Other information that you feel would be helpful to staff in designing a program that will effectively meet your needs?

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Eligible                      Not eligible                      Declined  
Referral Information  
Resource/Services  
Housing applications: \_\_\_\_\_  
ONH                      Priority Status (Homeless)                      Priority status (Domestic Violence)  
Rent assessment to be completed  
Releases of information required                      Probation and parole (in lieu of formal C.P.I.C.)  
Other \_\_\_\_\_

Additional Information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. I certify that all the information supplied is true and correct to the best of my knowledge.
2. I hereby agree to provide the Abbey House with signed releases of information deemed necessary to verify the information supplied in this application.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Directors Signature: \_\_\_\_\_