



### **Couchiching Jubilee House Program Information**

Couchiching Jubilee House (CJH) has created a comprehensive program of support for homeless or near homeless women and their dependent children. Women can stay at CJH for up to one year. The goal of the program is to support women during this transition in their lives by providing them with individualized and group supports. Through this programming women and their children learn new skills, regain old ones, identify strengths and build upon them. The key focuses of the program are connecting with community, linking to employment and education, and the finding and securing of affordable and stable housing.

To be considered for application, a woman must:

- Be homeless or near homeless and in need of transitional housing;
- Be female 16 years and older;
- Demonstrate situational vulnerability due to crisis, poverty, abuse or dramatic change in circumstances;
- Be willing to set personal goals and work towards their achievement;
- Agree to comply with the resident house rules;
- Participate in individual and group sessions;
- Sign Couchiching Jubilee House contract; and
- Be physically and mentally capable to participate in program.

### **Couchiching Jubilee House begins with Jubilee Connects**

Jubilee Connects is open to women aged 16+ to come together, to learn through interactive and informative workshops, to engage in conversation and to enjoy the afternoon in each other's company. Jubilee Connects meets weekly. Women do not need to be a client of Couchiching Jubilee House to attend.

**You are strongly encouraged to participate in the Jubilee Connects program.**

- Yes, I would like to participate in the **Jubilee Connects** program
- No, I would not like to participate in the **Jubilee Connects** program

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*Empowering women to improve their quality of life  
through a program of individualized support and transitional housing.*



**Applicant Information**

**Note: if this is NOT a self-referral, the referral source can complete on behalf of the applicant**

Name (First and Last)	Date of Birth	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>

Current Address (if applicable)

Apartment	City	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Telephone Number Where We Can Call You	Email Address (if applicable)
<input type="text"/>	<input type="text"/>

If you do not have a telephone, is there someone with whom you are in regular contact that we can call in order to reach you?

Name of Contact	Telephone Number	Relationship to Applicant
<input type="text"/>	<input type="text"/>	<input type="text"/>

Languages Spoken	Preferred Language
<input type="text"/>	<input type="text"/>

How well do you communicate in English?  Fluently  Fairly well  With difficulty  Not at all

If unable, is there a family member who speaks English fairly well?  Yes  No

Do you have communication needs? E.g. hearing impairment, visual impairment, aphasia, learning disability, nonverbal, AAC user. Please explain.

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Do you have children? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many? <input type="text"/>	Will they be living with you? <input type="checkbox"/> No <input type="checkbox"/> Yes
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Please provide names of children	Dates of Birth (day, month, year)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>



**Referral Source Information**

**Note: If not a self-referral, please have your source complete this section**

Name (First and Last)

Agency

Title/Position

Address

Postal Code

Telephone Number

Extension

Fax Number

Relationship to Applicant

How long have you known the applicant?

How many contacts do you have with the applicant per month?

Referral has been discussed with

Applicant     Family     Doctor(s)

If applicant is unaware of referral, please explain

Reasons for referral

**Applicant Personal Information**

**Current Living Arrangement**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> On my own           | <input type="checkbox"/> Spouse/Partner | <input type="checkbox"/> Children         | <input type="checkbox"/> Supportive Housing   |
| <input type="checkbox"/> With family/parents | <input type="checkbox"/> With friend(s) | <input type="checkbox"/> Boarding Home    | <input type="checkbox"/> Shared Accommodation |
| <input type="checkbox"/> Private Apt./House  | <input type="checkbox"/> Hostel/Shelter | <input type="checkbox"/> No fixed address | <input type="checkbox"/> Other _____          |

**Income Information**

- |  |  |                                 |  |
|--|--|---------------------------------|--|
| <input type="checkbox"/> Employment                        | <input type="checkbox"/> Employment Insurance/EI                   | <input type="checkbox"/> Family | <input type="checkbox"/> Canada Pension Plan (CPP) |
| <input type="checkbox"/> Disability Insurance              | <input type="checkbox"/> Ontario Disability Support Program (ODSP) |                                 |  |
| <input type="checkbox"/> Social Assistance (Ontario Works) | <input type="checkbox"/> No source of income at this time          |                                 |  |
| <input type="checkbox"/> Other                             | _____  |                                 |  |



**Strengths and Challenges**

What do you identify as being your strengths?

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What would your child(ren) identify as being their strengths?

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Have you ever struggled with the following:

	Victim	Other	Date	Circumstance/Frequency/Severity
Suicide - threats	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Suicide – attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Self abuse/self harm	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aggression – physical	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aggression – verbal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mishandling fire	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lack of attention while smoking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Assault – sexual	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Assault – physical	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Abuse of property	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sexual acting out	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Drug/alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Problems with anger	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Issues with collecting things	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____



**Legal Involvement**

Do you have any current or past legal involvement?  No  Yes  Unknown

Example: currently facing charges, on probation or parole, in custody, convictions, family court, etc.

If "Yes", please indicate dates, types of involvement and outcome

Present: \_\_\_\_\_  
\_\_\_\_\_

Past: \_\_\_\_\_  
\_\_\_\_\_

Conditions/restrictions resulting from legal involvement:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Conditions**

Do you have other physical or mental health conditions or challenges?  No  Yes  Unknown

Example: allergies, diabetes, hearing impairment, sight impairment

If "Yes", please describe

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

Name of Physician/G.P./Family Doctor (First name, last name)

\_\_\_\_\_

Address

\_\_\_\_\_

Postal Code

\_\_\_\_\_

Telephone Number

\_\_\_\_\_

Extension

\_\_\_\_\_

Hospital Affiliation

\_\_\_\_\_





**Self Reflection Section**

In your own words, please write a paragraph on why you think Couchiching Jubilee House will help your present situation. (use another sheet(s) of paper if required)

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**Are you a landed immigrant or refugee legally permitted to live and work in Canada?**

Yes \_\_\_\_\_ NO \_\_\_\_\_ Visa \_\_\_\_\_

**Would you like to self-identify as an Indigenous person?**

Yes \_\_\_\_\_ First Nation \_\_\_\_\_ Metis \_\_\_\_\_

No \_\_\_\_\_

\_\_\_\_\_  
**Signature of Applicant (if completed by Applicant)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature of person completing the form on behalf of the Applicant**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Relationship to the Applicant**

*On behalf of the Couchiching Jubilee House, thank you very much for sharing this information with us.*

*Everything that you have shared will be kept in the strictest confidence*



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**Personal References**

**Please give 3 personal references (Please advise those references that they will likely be contacted.)**

Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone

**Who can you count on when times are tough?**

Name	Relationship
Contact information – email, phone, address if applicable	

**Next Steps:**

Your application will be placed on a waitlist if there are no vacancies.

Applicants will be called for an interview when a spot opens up. Interviews will be granted based on criteria, priority/need and placement on our list. It is difficult to say when this will happen because women can stay in our residence for up to a year and we typically receive over 60 applications per year

Please submit this application

In person to Couchiching Jubilee House office, 79 Colborne St. E. Orillia, ON

Or by mail: P.O. Box 272, Orillia, ON L3V 6J6

Or by Fax: 705-326-2767.