



# SUPPORTED LIVING APPLICATION

Pour recevoir le présent formulaire en français, veuillez envoyer un courriel à l'adresse [CASL@gov.nt.ca](mailto:CASL@gov.nt.ca) ou composer le 1-867-767-9030, poste 49202.

## Definition:

Supported Living helps adults with disabilities live as independently and safely as possible and participate fully in their community. Support with daily living tasks can be provided in a person's own home, or in supported living accommodations. A range of services can be provided based on individual assessed needs, which can vary from minimal non-medical supports to 24-hour non-medical support.

To be eligible for publicly funded supported living services, the applicant must:

- Have a permanent or long-term disability (cognitive, physical, or mental health) that requires support with activities of daily living or instrumental activities of daily living;
- Be 19 years of age or older (or turning 19 in the **next 12 months of the application date**);
- Be an NWT resident

## Application Process:

The Supported Living Application is to be completed by one of the following designated Health and Social Services (HSS) professionals:

- Licensed or registered Social Worker, Occupational Therapist, Nurse (Nurse Practitioner, Registered Nurse, Licensed Practical Nurse); or
- Adult Service Worker.

The completed application form and any additional assessments are to be emailed through **secure file transfer** to the Committee for Application to Supported Living (CASL) at: [CASL@gov.nt.ca](mailto:CASL@gov.nt.ca).

CASL will review applications and determine the applicant's eligibility to Supported Living and will connect the applicant to a case manager who will support the applicant.

SECTION 1 : APPLICANT INFORMATION				
Full legal name		Preferred name		
Last name	First name			
Date of birth	Gender	Phone no.	Email	
Address				
Street address		Unit no.	Lot, block, plan	Postal code
NWT Health care number		<b>Note:</b> If the applicant does not have a current NWT Health Care card, please support the applicant in attaining a valid NWT Health Care card. A current NWT Health Care card is required for intake to supported living services.		

SECTION 2 : ELIGIBILITY	
1. Does the applicant have a permanent or long-term disability (cognitive, physical, or mental health) that requires support with activities of daily living or instrumental activities of daily living?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Is the applicant 19 years of age or older (or turning 19 in the <b>next 12 months of the application date</b> )	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Is the applicant a NWT resident	<input type="checkbox"/> No <input type="checkbox"/> Yes

SECTION 3 : APPLICANT DECISION MAKING STATUS			
<b>3.1 Applicant Guardianship status</b>			
<input type="checkbox"/> Own legal decision maker (e.g. has no guardianship order)			
<input type="checkbox"/> An application for guardianship has been submitted. Please provide date when application was submitted Please indicate if the application is for Private or Public Guardian			
<input type="checkbox"/> Has a <b>Private</b> Legal Guardian*			
<input type="checkbox"/> Has a <b>Public</b> Legal Guardian			
*For Private Guardian, please indicate			
Full name		Phone no.	Email
Last name	First name		
Relationship to the applicant			

**3.2 Applicant Trusteeship status**

- Own trustee (e.g. has no trusteeship order)
- Power of Attorney
- An application for Trusteeship has been submitted. Please provide date when application was submitted  
Please indicate if application is for Private or Public Trustee
- Has a **Private** Legal Trustee\*
- Has a **Public** Legal Trustee

*\*For Private Trustee, please indicate*

Full name	Phone no.	Email
Last name   First name		
Relationship to the applicant		

**SECTION 4: HEALTH HISTORY****4.1 Diagnoses and Assessments**

	Primary Diagnosis/Condition	Secondary Diagnoses/Conditions
1. Please list all diagnoses and known conditions of the applicant		
2. Has the applicant undergone a formal cognitive or psychological assessment?		
<input type="checkbox"/> No <input type="checkbox"/> Yes (If <b>Yes</b> , please provide the assessment – if in the last 5-10 years)		
3. Does the applicant have any medical and/or nursing needs?      If <b>Yes</b> , please describe the need and services received or needed		
<input type="checkbox"/> No <input type="checkbox"/> Yes		

**4.2 Mental Health History**

1. Is the applicant currently experiencing an acute or unstable mental health condition?      Please describe	
<input type="checkbox"/> No <input type="checkbox"/> Yes <b>Noting:</b> If yes, please support the applicant in seeking appropriate psychiatric/ mental health and/or medical care to stabilize their condition.	
2. Has the applicant experienced an acute or unstable mental health condition?      Please describe	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. Has the applicant received inpatient care for psychiatric or mental health conditions?      Please provide dates and length of stay duration of admission	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
4. Does the applicant have current suicidal ideation?      Please indicate the current assessed risk as per the NTHSSA Suicide Risk Assessment tool, and describe or attach the applicant's Safety and Wellness Plan.	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
5. Does the applicant have history of suicide attempts?      Please describe	
<input type="checkbox"/> No <input type="checkbox"/> Yes	

**4.3 Admission History**

1. Has the applicant been admitted to the hospital in the past year.      Please provide details of admission	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
2. Over the last 12 months, how many times has the applicant required care at an Emergency Room or Health Center.	

4.4 Medication				
	Medication	Reason	Frequency	Mode (e.g. oral; injection; other – specify)
1. Please list any prescribed medications the applicant is currently taking.				
2. Have there been any challenges with the applicant's medication management (i.e. taking their medication as prescribed, willingness to take medication, other)		If Yes, please explain		
<input type="checkbox"/> No <input type="checkbox"/> Yes				

**SECTION 5 : IMPAIRMENTS**

1. Does the applicant have a visual impairment?		Please describe		
<input type="checkbox"/> No <input type="checkbox"/> Yes				
2. Does the applicant have a hearing impairment?		Please describe		
<input type="checkbox"/> No <input type="checkbox"/> Yes				
3. Does the applicant have physical or mobility impairments?		Please describe		
<input type="checkbox"/> No <input type="checkbox"/> Yes				
4. Does the applicant have a cognitive impairment?		Please describe and complete the table below		
<input type="checkbox"/> No <input type="checkbox"/> Yes				
Cognitive Function	No	Occasionally	Yes	
Is this person fully aware of his or her surroundings?				
Is this person fully aware of time ?				
Does this person remember and follow simple instructions?				
Does this person respond to his or her name?				
Does the person recognize friends and relatives?				
5. Does the applicant have a speech or communication impairment?		Please explain		
<input type="checkbox"/> No <input type="checkbox"/> Yes				
a) Please indicate how the applicant communicates		b) Please indicate the applicant's preferred language		c) Please indicate the applicant's level of communication ability
<input type="checkbox"/> Verbally	<input type="checkbox"/> Other	<input type="checkbox"/> Preferred language	<input type="checkbox"/> Able to communicate needs and wants	
<input type="checkbox"/> Written		<input type="checkbox"/> Other languages spoken or understood	<input type="checkbox"/> Has limited ability to communicate needs and wants	
<input type="checkbox"/> Sign language			<input type="checkbox"/> Unable to communicate needs and wants	
<input type="checkbox"/> Gestures				

**SECTION 6 : CURRENT SUPPORTS AND SUPPORT NEEDS**

**6.1 Current Living Situation**

1. Please indicate the applicant's current living situation

- Lives alone  
  Lives with family/caregiver  
  Lives with roommate(s)  
  Homeless/unstable housing  
  Semi-supported housing (e.g. Housing First, Women's shelter)
- Child Family Services placement. Please specify if the placement is in-territory or out-of-territory
- In-territory supported living. Please specify
- Out of territory supported living. Please specify
- Other

2. Please describe the applicant's current informal support network, including the availability and reliability of family, friends, or others who assist with daily tasks, supervision, or support?

**6.2 Current Supports**

1. Indicate all formal supports the applicant is currently accessing

Program or Service	Please indicate the types of support received	Indicate the frequency and duration
Home Care		
Community Mental Health / Outreach Nurse		
Respite		
Day Programming		
Shelter services		
Child and Family Services		
Counselling		
Adult Services / Social Support Case Managers		
Salvation Army Independent supported living program		
Inclusion NWT Independent supported living program		
Other – please describe		

Please add any additional comments on current support

**6.3 Support and Supervision Needs**

1. Does the applicant require continuous support or supervision all the time?

- No Please indicate the estimated amount of time the applicant can safely be left alone
- Yes Please explain

2. Does the applicant require a dedicated 1:1 support person? Please check **one** box

- Yes Dedicated 1:1 support is needed all the time. Please explain
- Yes Dedicated 1:1 support is needed but not all the time. Please explain why, when and for how long 1:1 support is needed
- No The applicant does not need dedicated 1:1 support all the time and is safe in a setting with shared support staff.

3. Does the applicant require support staff to be present overnight?

- No  Yes

If **Yes**, would support staff need to remain awake overnight?

- No  Yes, please explain

4. Does the applicant ever require support from two persons?

- No  Yes. Please indicate by checking **one** of the boxes below

- Applicant requires brief or occasional two-person support. Please describe which tasks, activities or situations require two-person support
- Applicant requires regular and more intensive two-person support. Please describe which tasks, activities or situations require two-person support
- Applicant requires continuous support or supervision from two persons at all times. Please explain

Please add more information to describe the support and supervision needed, if applicable

**6.4 Activities of Daily Living (ADLs)**

1. For each ADL, select the required level of support needed.

Activities of Daily Living	Independent	Requires support in setup, supervision, and/or cueing, but is then independent	Requires assistance of one person throughout the task	Requires two-person assistance at any time during the task	Notes/ Safety Concerns
Bathing/ showering					
Dressing					
Eating/ Feeding					
Grooming (e.g. hair brushing, shaving, nail care)					
Oral care					
Transferring/ mobility					

2. Please indicate if any support is required for elimination/continence

- Manages independently and needs no support
- Occasional incontinence (e.g. weekly or less) and requires minimal support
- Daily incontinence; needs support to manage
- Fully incontinent with no awareness of incontinence, requires two-person support

Please provide any additional information

3. Assistive devices. Please outline any assistive devices or equipment that the applicant currently uses (e.g. walker, cane, wheelchair, shower chair, raised toilet seat; hearing aids; glasses)

4. Are there any accessibility accommodations needed in the applicant's home to best support their needs? If **Yes**, please describe

No  Yes

**6.5 Instrumental Activities of Daily Living (IADLs)**

1. For each IADL, select the required level of support needed

Instrumental Activities of Daily Living	Independent	Requires support in setup, supervision, and/or cueing, but is then independent	Requires assistance of one person throughout the task	Requires two-person assistance at any time during the task	Notes/ Safety Concerns
Meal preparation					
House cleaning					
Laundry					
Scheduling/ getting to appointments					
Medication management					
Managing finances					
Shopping for necessities					
Transportation/ community access					

Please provide any additional information on the IADL supports required by the applicant

**SECTION 7 : BEHAVIOUR**

1. Does the applicant exhibit, or have a history of, aggressive or violent behaviours towards self, staff or others that may pose a safety risk? Please provide history and description of any aggressive or violent behaviour

No  Yes

2. Does the applicant have any triggers that impact their behaviour? Please describe

No  Yes

3. Is the applicant at risk for elopement or exit-seeking behaviours? Please describe

No  Yes

4. Does the applicant have a behavioural support plan?

No  No, but the applicant would benefit from a behavioural support plan  Yes. Please attach the behavioural support plan

Please provide any additional information regarding the applicant's behaviour and/or any other safety concerns

5. Are there any concerns with the applicant living with a roommate(s)

No  Yes

Please describe concerns

**SECTION 8 : VULNERABILITY**

1. Is there history of eviction or discharge from housing settings?

Please describe

No  Yes

2. Is the applicant able to determine who is trustworthy?

Please describe

No  Yes

3. Is the applicant easily influenced by peers?

Please describe

No  Yes

4. Can the applicant determine when someone is taking advantage of them?

Please describe

No  Yes

5. Is the applicant vulnerable to others taking over their home (e.g. others staying longer than welcome; others using the home for other purposes such as drug dealing or trafficking)?

Please describe

No  Yes

6. Is the applicant **currently** experiencing any type(s) of abuse or neglect such as emotional, physical, sexual or financial?

Please briefly describe the type(s) of abuse

No  Yes

7. Does the applicant have a **history** of experiencing physical and/or sexual assault, financial abuse or neglect in the past 5 years?

Please briefly describe the type(s) of abuse

No  Yes

**SECTION 9 : SUBSTANCE USE**

**9.1 Current Substance Use**

1. Does the applicant **currently** use substances? (e.g. alcohol, cannabis, illicit drugs)

No. Please skip to **9.2 History of Substance Use**  Yes. Please indicate below what substance(s) and frequency of use

Substance (e.g. alcohol; cannabis; illicit drugs)	Frequency of use (e.g. daily, weekly, or occasional)

2. Does the applicant exhibit drug-seeking behaviour? Please describe behaviour  
 No  Yes

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3. If the applicant uses substances, could the applicant consent and comply to abstain from substance use while on site in a supported living home? If **Yes**, please skip to **9.2 History of Substance Use**  
 No  Yes

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4. Does the applicant have a substance use disorder or addiction? Please describe  
 No. Please skip to **9.2 History of Substance Use**  Yes

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5. Does the applicant recognize they have a substance use disorder?  
 No  Yes

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6. Would the applicant benefit from a harm reduction approach to support their substance use? Please describe  
 No  Yes

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7. Is the applicant eligible; do they have the capacity; and would they consent to participate in a residential or on-the-land addictions treatment program? Please describe  
 No  Yes

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8. Is the applicant currently participating in an addiction treatment/maintenance program? Please describe  
 No  Yes

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**9.2 History of Substance Use**

1. Does the applicant have a **history** of substance use (e.g. alcohol, cannabis, illicit drugs)  
 No. Please skip to next section, **10.0 Justice System Involvement**  Yes. Please indicate below

Substance (e.g. alcohol; cannabis; illicit drugs)	History of use (e.g. daily, weekly, or occasional)	Date of last use

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2. Has the applicant attended substance use treatment in the past? If **Yes**, please describe the program, provide dates and indicate the outcome of the treatment program  
 No  Yes

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Use this space to add additional detail if needed

**SECTION 10 : JUSTICE SYSTEM INVOLVEMENT****10.1 Criminal/Legal History**

The following questions help the committee understand the applicant's supports needs, safety planning, and program fit. Please note a criminal record check may be requested.

1. Does the applicant have a criminal record? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe
2. Does the applicant have a history of criminal behaviour? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe the nature of the behaviour
3. Is the applicant currently involved with the justice system? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe
4. Are there current legal conditions to which the applicant must abide? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe relevant conditions
5. Is the applicant required to attend court, counselling, or justice related programs? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please outline the frequency/requirements

**SECTION 11 : ADDITIONAL INFORMATION****11.1 Supported Living Services Preferences**

1. Please indicate the supported living services requested <input type="checkbox"/> Supported living services only (e.g. The applicant will remain in their current living situation/ accommodations) <input type="checkbox"/> Supported living services and accommodations	
2. The applicant is agreeable to living in a shared living setting such as an apartment or house with other supported living clients. <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe
3. The applicant is agreeable to living in other communities in the NWT or out-of-territory, if applicable. <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe
4. If deemed eligible for supported living services within the territory, please rank the applicant's preferred region of service from 1-3. Note that preferences are considered but cannot always be accommodated.	<input type="checkbox"/> Yellowknife <input type="checkbox"/> Inuvik <input type="checkbox"/> Hay River <input type="checkbox"/> No preference

**11.2 Ability to pay for Supported Living Services**

1. The applicant has the ability to pay for supported living room and board expenses, if applicable. <input type="checkbox"/> No <input type="checkbox"/> Yes	Please describe
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**11.3 Please provide any additional assessments or reports that will assist the committee in determining eligibility and appropriate supported living settings for the applicant.**

**Note:** Additional documentation is not required, however, fulsome and comprehensive information will enable the committee to accurately determine eligibility, appropriate supported living settings, and waitlist priority if required.

**Assessments**

- Medical or diagnostic reports
- Psychological or cognitive assessments
- Occupational therapy/physiotherapy functional assessments

**Reports:**

- Hospital discharge summaries
- Previous support agency records
- Current rehabilitation plan
- Behavioural Support plan

Please provide any additional information that would be relevant to the committee in determining the applicant's eligibility to supported living

**SECTION 12 : REFERRAL SOURCE CONTACT INFORMATION****Contact Information : HSS Professional completing the Supported Living Application:**

Full name		Health and Social Services Job Title
Last name	First name	
Phone no.	Email	Signature X

**SECTION 13 : DECLARATION & CONSENT**

The information collected in this Supported Living Application form will be used by CASL for purposes of determining the eligibility of the applicant to publicly funded supported living services, and when determined eligible, this information will be disclosed to the appropriate supported living health and social services authority positions and GNWT funded supported living service providers (both in-territory and out-of-territory, where applicable) for the purposes of determining an appropriate supported living placement for the applicant.

By signing this form I declare/confirm/agree that

- The Supported Living Program and Application process has been explained to me.
- I declare that all of the information provided in the Supported Living Application for \_\_\_\_\_ is complete and correct to the best of my knowledge. Name of Applicant
- My consent is in effect until the termination of my participation in the Supported Living Program and will be reviewed annually.
- I understand that I can withdraw my consent at any time.
- I understand how my personal health information will be handled and my privacy protected.
- I understand a signed copy of this consent form will be stored in the confidential electronic files at the Department of Health and Social Services.
- I understand and am willing to participate voluntarily in a supported living program that aims to support clients to participate in their daily lives as independently as possible.
- I will receive a signed copy of this consent form for my records.

_____	_____
Name of Applicant	Name of Legal Guardian, if applicable
X _____	_____
Signature of Applicant or Legal Guardian, if applicable	Date (YYYY-MM-DD)

**Privacy**

Personal health information collected on this form is protected under the *NWT Health Information Act* and will not be used or disclosed unless allowed or required by the *NWT Health Information Act* or another Act.