# Sue Bujold Floor, Application

# General Information

(Please fill in electronically, and then print for signature. Either mail in or scan and email)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | | |
| **Gender Identification:** | Female  Trans        Other | | |
| **Today’s Date:** |  | **Birthdate:** |  |
| **Primary Phone:** |  | **Other Phone:** |  |
| **Address:** |  | | |
| **City, Province:** | , BC | **Postal Code:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you currently homeless or precariously housed? |  | Yes | No | |
| Do you live in a Single Room Occupancy hotel in the DTES? |  | Yes | No | |
| Is your current housing operated by: |  | Atira Women’s Resource Society | | |
|  |  | Atira Property Management Inc. | | |
|  |  | Other society: | |  |
|  |  | Privately owned: | |  |
| Do you have any health conditions or disabilities? |  | Mental health concern | | |
|  |  | Problematic substance use. | | |
|  |  | Physical health concern - describe: | | |
|  | | | | |
|  | | | | |
|  | | | | |

|  |  |  |
| --- | --- | --- |
| What is the best way to contact you? |  |  |
| What day of the week and time of day is best to reach you? |  |  |

How did you find out about the Sue Bujold program?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Atira’s website |  |  | Your doctor or nurse | |
|  | Referral from another organization |  |  | Volunteer website: |  |
|  | Atira’s Homeless Prevention program |  |  | Newspaper or magazine: |  |
|  | A friend |  |  | Other: |  |

## Emergency Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Emergency Contact:** |  | | |
| **Relationship to You:** |  | | |
| **Primary Phone:** |  | **Other Phone:** |  |
| **Address:** |  | | |
| **City, Province:** | , BC | **Postal Code:** |  |

Additional Questions

### Personal Information

*Information is collected for planning and reporting purposes. Answers do not affect your eligibility for housing.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you identify as being an Aboriginal person of Canada? |  | Yes | | No | | |
|  |  | First Nations | Métis | | Inuit | Other |

***Mobility***

|  |  |  |  |
| --- | --- | --- | --- |
| Do you use a wheelchair or walker? |  | Yes | No |

### Additional Questions

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke? |  | Yes | No |
| Are you willing to sign a non-smoking agreement? |  | Yes | No |

Anything else you wish us to know?

|  |
| --- |
|  |
|  |
|  |

## Signature

|  |  |
| --- | --- |
| Signature: |  |
| Printed Name: |  |
| Date: |  |