

Indicate "N/A" if not applicable to the applicant

### Section 1: Applicant Personal Information

Full Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_

Eye Colour: \_\_\_\_\_ Language Spoken/Understood: \_\_\_\_\_

Social Insurance # (SIN): \_\_\_\_\_

Personal Health Identification # (PHIN): \_\_\_\_\_

Manitoba Health #: \_\_\_\_\_ Treaty #: \_\_\_\_\_

Employment and Income Assistance (EIA) Number: \_\_\_\_\_

### Section 2: Parent/Guardian/Caregiver Information

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Section 3: Emergency Contact Information

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Section 4: Substitute Decision Maker (SDM) Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Personal Care, Management of Property or Both: \_\_\_\_\_

### Section 5: Community Service Worker (CSW) Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Section 6: Employment and Income Assistance (EIA) Worker Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Section 7: Reason for Referral

Residential (specify location if known): \_\_\_\_\_

Day Program (specify location if known): \_\_\_\_\_

Crisis

Respite

Supported Independent Living (SIL)

Other (please specify): \_\_\_\_\_

## Section 8: Applicant's Current Supports

Supported by Another Agency (indicate which one(s), how long, type of support):

Refused Access to Another Program (indicate why): \_\_\_\_\_

Dismissal from Another Program (indicate why): \_\_\_\_\_

Institution

School

## Section 9: Previous Day and Residential Placements

1. Placement: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Time Period: From \_\_\_\_\_ to \_\_\_\_\_

Please Describe Placement 1:

2. Placement: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Time Period: From \_\_\_\_\_ to \_\_\_\_\_

Please Describe Placement 2:

## Section 10: Education and Training

School: \_\_\_\_\_

Age at Graduation: \_\_\_\_\_ Years in School: \_\_\_\_\_

Type of Education:

Segregated (non-graded)

Integrated (all classes)

Integrated (non-academic)

Special Facilities

Academic

Other (please specify): \_\_\_\_\_

Unknown

## Section 11: Transportation Used

Public Transportation

Van

Walking

Other (please specify): \_\_\_\_\_

## Section 12: Medical

### Physician

Name: \_\_\_\_\_

Clinic & Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical Concerns:

Diagnosis:

Allergies:

### Specialists

1. Name: \_\_\_\_\_

Clinic & Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical Concerns:

2. Name: \_\_\_\_\_

Clinic & Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical Concerns:

3. Name: \_\_\_\_\_

Clinic & Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical Concerns:

### Medications

Please list all medications applicant is currently taking or attach a medication list/sheet:

Please list any behaviours that interfere with daily living and how you support this person:

### Dentist

Name: \_\_\_\_\_

Clinic & Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Dental Concerns:

### Optometrist

Name: \_\_\_\_\_

Clinic &amp; Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Optometry Concerns:

### Ambulation

 No Impairment Unsteady Gait/Excessively Slow Other (please specify): \_\_\_\_\_

### Sight

 No Impairment Visually Impaired (not correctable)

### Hearing

 No Impairment Hearing Impaired (including hearing deficit that is correctable) Deaf Other (please specify): \_\_\_\_\_

### Fine and Gross Motor Coordination

- No Impairment
- Impairment (please specify): \_\_\_\_\_

### Communication

- Speaks Clearly in Sentences
- Speaks Unclearly in Sentences
- Uses Gestures (please specify): \_\_\_\_\_
- Uses Communication Aides/Devices (please specify): \_\_\_\_\_
- Uses Sign Language

### Section 13: Required Supports

Indicate in the box which skills the applicant can complete independently, and which skills require support.                    **I = INDEPENDENT**      **S = SUPPORT REQUIRED**

- Attendance and Punctuality
- Personal Care and Grooming (washing hair, bathing, shaving, etc.) Explain Support Needed:  
\_\_\_\_\_

- Making Lunch
- Banking/Money Management
- Using the Telephone
- Making Medical Appointments
- Shopping for Necessities
- Preparing Meals/Using the Stove
- Clothing Purchases
- Doing Laundry
- Ironing Clothes
- Going out into the Community Independently



- Administering Medications
- Travelling in the Community Independently
- Spending Time at Home Alone (for how long?): \_\_\_\_\_

Is there anything else we may have missed?

### Section 14: Academic Skills (please check all that apply for each)

#### Mathematics

- Simple Counting of Money
- Simple Addition and Subtraction
- Complex Skills (divide, multiply, etc.)
- None of the Above

#### Time Awareness

- Understands Hours and Minutes
- Can Utilize Hour and Minute Hands for Appointments
- Aware of Time with Prompting
- Unaware of Time

#### Word Recognition

- Distinguishes Between Symbols
- Recognizes Some Words
- Simple Reading (part of a magazine or paper, etc.)
- None of the Above

Please describe the applicant (personality, likes and dislikes, etc.):

Please describe interests, activities and hobbies:

Please provide a brief history (include family members, network of friends and additional supports):

Please provide any other pertinent information:

Date of Agreement (mm/dd/yyyy): \_\_\_\_\_

Applicant's Start Date (mm/dd/yyyy): \_\_\_\_\_

Caregiver/Agency Signature: \_\_\_\_\_

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

Authorized Funding from Manitoba Family Services at: \_\_\_\_\_

Family Services Worker Signature: \_\_\_\_\_