Application for Services

Sara Riel Inc.

66 Moore Avenue

Winnipeg, Manitoba

R2M 2C4

Intake Direct Line: 204-237-7165

Intake Fax: 204-233-2564

IMPORTANT INFORMATION * PLEASE READ

Sara Riel Inc. Application for Services is the beginning of a process which attempts to expedite providing you with the right services at the right times.

Wait lists do exist from time-to-time, however, so if you find yourself in an immediate crisis situation, please also take a look at the inside cover (page2) for available resources.

CT-100
04.2017

If you are experiencing thoughts of suicide:

Manitoba Suicide Line:
24 Hours (toll free)
1-877-435-7170

If you are experiencing or wish to report abuse:

Winnipeg Police Service:

To report a sexual assault in emergency situation, call
9-1-1

For non emergent calls to report to police, call
204-986-6222

To speak to a detective in confidence, call
204-986-6245

Klinic Sexual Assault Line:
204-786-8631

Seniors Abuse Line:
204-945-1884

Protection for "Persons in Care":
204-788-6366

Sara Riel inc.
Compassion. Respect. Recovery.
Compassion. Respect. Rétablissement.

Other Community Resources

Klinic Crisis Line	204-786-8686
WRHA Mobile Crisis Service	204-940-1781
TTY Deaf access Line	204-779-8902
WRHA Crisis Stabilization Unit	204-940-3633
TTY Deaf access Line	204-957-7101
Community Mental Health Services (self-referral)	204-940-2655
Mental Health Advocate (CMHA)	204-982-6100
Seneca Respite (Sara Riel Inc.)	204-231-0217
Seneca Warm Line (7pm – 11pm only)	204-942-9276
Health Links	204-788-8200
AIDS/STD Information Line	204-945-2437
Manitoba Schizophrenia Society	204-786-1616
Mood Disorders Association	204-786-0987
Anxiety Disorders Association of Manitoba (ADAM)	204-925-0600
Addictions Foundation of Manitoba (AFM)	204-944-6200
Problem Gambling Helpline (toll free)	1-800-463-1554
Youth Mobile Crisis Team	204-949-4777
Kids Help Phone (toll free)	1-800-668-6868
Age and Opportunity	204-956-6440
Winnipeg Harvest	204-982-3660

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PERSONAL INFORMATION

First Name ________________________ **Initial(s)** _______ **Last** ____________________

Telephone ____________________________ **Cell/Alternate** ____________________

Email ____

Date of Birth (mm/dd/yyyy): ___ ___/ ___ ___/ ___ ___ ___ ___

Identified Sex: ☐ Male ☐ Female ☐ Other______________________

Marital Status: ☐ Single ☐ Married ☐ Common Law **Number of Children:**________
☐ Separated ☐ Divorced ☐ Widowed

Manitoba Health Services Card (MHSC) Registration Number (6 digit #) ___ ___ ___ ___ ___ ___

Manitoba Health – Personal Health I.D. Number (PHIN) (9 digit #) ___ ___ ___ ___ ___ ___ ___ ___ ___

ADDRESS INFORMATION

Address ____

City/Town ____________________________ **Prov.** ______ **Postal Code** ____________

At this address since (mm/dd/yyyy) ___ ___/ ___ ___/ ___ ___ ___ ___ **Monthly Rent** $________

ETHNICITY

Citizenship Status
☐ Canadian ☐ Refugee ☐ Landed Immigrant ☐ Other ____________________

Preferred Language:
☐ English ☐ French ☐ Other______________________________

Functional Languages:
☐ English ☐ French ☐ Other______________________________

First Nations Ancestry
☐ Yes "Treaty" Number ______________________________

REFERRAL SOURCE

Please indicate if you were referred to Sara Riel by an outside agency/worker and/or if they helped you fill in the application:

Name:____

Title:____

Organization/Agency: ______________________________________

Signature ____________________ Date (mm/dd/yyyy): ___ ___/ ___ ___/ ___ ___ ___ ___

The priority of my self-identified needs is as follows:

In the space provide, rank your needs in order (1 being the highest need) leave blank if the service is not of importance or interest to you. Also check any/all of the topics you would like to address below the headings.

*** If locating or retaining housing becomes a need for any of our service recipients, speak to your worker.**

______ **MENTAL HEALTH COUNSELLING** (Riel Recovery Group is a prerequisite)

- ☐ Issues of Abuse
- ☐ Addictions Management
- ☐ Crisis Intervention
- ☐ Family/Supports
- ☐ Conflict/Anger Management
- ☐ Coping/Self Esteem
- ☐ Dealing with Grief and Loss
- ☐ Medication Management
- ☐ Psychiatric Concerns
- ☐ Physical/Health Needs
- ☐ Spiritual Needs
- ☐ Legal Issues/Rights
- ☐ Sexuality/Relationships
- ☐ Thoughts of Suicide

______ **COMMUNITY MENTORSHIP** (Independent Living Skills Development)

- ☐ Housekeeping/Maintenance
- ☐ Financial/Budgeting
- ☐ Nutrition/Food Preparation
- ☐ Social Networking
- ☐ Personal Self Care
- ☐ Safety and Security
- ☐ Communication Skills
- ☐ Transportation/Accessibility.

______ **EMPLOYMENT SERVICES**

- ☐ Supported Job Search
- ☐ Career Coaching
- ☐ Education Planning
- ☐ Pre-Employment Skills Training
- ☐ Employment Counselling

______ **SENECA RESPITE** (Peer-Supported, 5-Night Stays)

HEALTH NFORMATION

Please indicate your Mental Health Diagnosis *(Please check all that apply)*

- ☐ Adjustment Disorder
- ☐ Anxiety Disorder
- ☐ Attachment Disorder
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Obsessive/Compulsive Disorder
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychosis *(not otherwise specified)*
- ☐ Schizo-Affective Disorder
- ☐ Schizophrenia
- ☐ Social Phobia

Other *(please identify and explain)*: ______________________________

Is there a Concurrent Diagnosis of a Developmental Disorder? ☐ Yes ☐ No

- ☐ Autism Spectrum/Asperger's
- ☐ Brain Injury
- ☐ Learning Disability
- ☐ Dementia
- ☐ Fetal Alcohol Spectrum

Please identify and explain: ______________________________

____

Is there a Concurrent Physical Condition or Disability? ☐ Yes ☐ No

Please identify and explain: ______________________________

____

SIGNS AND SYMPTOMS

Please indicate if you are experiencing any of the following: *(check all that apply)*

- ☐ Agitation/Restlessness
- ☐ Anger
- ☐ Anxiety (undiagnosed)
- ☐ Apathy/lack of motivation
- ☐ Arson
- ☐ Auditory Hallucinations
- ☐ Changes in communication
- ☐ Changes in eating patterns
- ☐ Changes in sleeping patterns
- ☐ Compulsive behaviours
- ☐ Confusion
- ☐ Depression (undiagnosed)
- ☐ Dissociative episode
- ☐ Excessive Spending
- ☐ False Beliefs
- ☐ Fixed Ideas
- ☐ Heightened sexual preoccupation
- ☐ Homicidal Thoughts
- ☐ Inability to maintain employment
- ☐ Misses appointments
- ☐ Non-compliant w/medications
- ☐ Non-compliant w/treatments
- ☐ Panic Attacks
- ☐ Physical aggression
- ☐ Physical complaints
- ☐ Property damage
- ☐ Self-harm (slashing/burning)
- ☐ Social withdrawal/isolation
- ☐ Suicidal thoughts
- ☐ Verbally aggressive
- ☐ Visual hallucinations

☐ Other (please specify) ______________________________

ADDICTION

Please indicate a current harmful or dependent involvement with the following:

- ☐ Alcohol
- ☐ Non-prescription (Street) Drugs
- ☐ Shopping *(excessive or compulsive spending)*
- ☐ Technology *(internet/video-gaming)*
- ☐ Prescription Drugs
- ☐ Solvents *(gasoline, glue, paint thinner,)*
- ☐ Gambling/Gaming
- ☐ Food *(binging/purging; eating other than out of hunger/nutrition)*

Please list any specific prescription and non-prescription drugs ______________________________

____

LEGAL

Please indicate any legal involvement:

- ☐ Certificate of Leave
- ☐ On Parole
- ☐ Child Custody Order
- ☐ Restraining Order
- ☐ Order of Committeeship
- ☐ On Probation
- ☐ Order of Recognizance
- ☐ Peace Bond
- ☐ Power of Attorney
- ☐ Public Trustee
- ☐ Prevention Order
- ☐ Protection Order

☐ Other *(please specify)* ______________________________

Please indicate any involvement with the Criminal Justice System:

- ☐ Current involvement?
- ☐ Criminal record?
- ☐ Incarcerated in past 3 years?

Convictions:

- ☐ Physical assault
- ☐ Sexual assault
- ☐ Weapons offence(s)

☐ Other *(please specify)* ______________________________

EDUCATION, EMPLOYMENT AND INCOME

Please indicate your highest level of education completed:

- ☐ High School/GED
- ☐ Trade School
- ☐ College/University

☐ Other *(please specify)* ______________________________

Please indicate your current employment status

- ☐ Unemployed
- ☐ Self-Employed
- ☐ Employed *(____ Full-Time ____ Part-Time ____ Casual ____ Seasonal)*
- ☐ Retired
- ☐ Volunteer

☐ Other *(please specify)* ______________________________

Please indicate your current sources of income *(Please check all that apply)*

- ☐ Employment
- ☐ Savings
- ☐ Family
- ☐ Employment Insurance (EI)
- ☐ Employment & Income Assistance (EIA)
- ☐ EIA Disability
- ☐ Canada Pension Plan (CPP)
- ☐ CPP Disability
- ☐ Guaranteed Income Supplement (GIS)
- ☐ Old Age Security (OAS)
- ☐ Other Pension
- ☐ Shelter Benefit/Rent Aid
- ☐ Private Insurance
- ☐ Portable Housing Benefit (PHB)

☐ Other *(please specify)* ______________________________

OTHER SERVICE UTILIZATION

Please indicate the number of times you have used each of these services, in the last year?

_____ 911 Emergency Services

_____ Hospital Emergency Room Visit

_____ Mental Health (In-Patient)

_____ Mental Health (Out-Patient)

_____ Crisis Response Centre (CRC)

_____ Crisis Stabilization Unit (CSU

_____ Mobile Crisis Unit

_____ Seneca Warm Line

_____ Klinic Crisis Line

_____ Suicide Hotline

☐ Other *(please specify)*____

EMERGENCY INFORMATION

Please provide emergency contact information

First Name ______________________ **Initial(s)** ________ **Last** ______________________

Telephone ______________________ **Cell/Alternate** ______________________

Address ____

City/Town ______________________ **Prov.** ________ **Postal Code**______________________

Relationship: ☐ Spouse or Partner ☐ Parent ☐ Sibling ☐ Son or Daughter ☐ Friend or Neighbour

☐ Other *(please specify)* ____

In case of emergency, an employee of Sara Riel Inc. has permission to contact the person listed above.

Signature ______________________________ Date (mm/dd/yyyy): __ __/ __ __/ __ __ __ __

Mental Health Clinician

Psychiatrist/Psychologist/Therapist/Counsellor

Name___________________________

Group/Org___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Health Care Provider:

Personal Physician/Clinician/Hospital

Name___________________________

Group/Org___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Income Support:

Employment & Income Assistance (EIA)/Canadian Pension Plan (CPP)

Name___________________________

Case Number___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Community Mental Health Provider:

Community Mental Health Worker /CRC/CSU/Mobile Crisis

Name___________________________

Group/Org___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Corrections/Justice:

Public Trustee/Parole Officer/Mental Health Court/F.A.C.T. Team

Name___________________________

Relationship___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Other Services Worker:

Child and Family Services (CFS) Worker, Vocational Rehabilitation Worker

Name___________________________

Relationship___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Family:

Please Specify

Name___________________________

Relationship___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Other:

Please specify

Name___________________________

Relationship___________________________

Address___________________________

City______________ Postal Code__________

Phone______________ Fax______________

E-mail___________________________

Sara Riel Inc. Authorization for Release of Information

BY SIGNING THIS DECLARATION BELOW, I UNDERSTAND THAT…

- Sara Riel Inc. may require to both obtain and share my private health and financial information, social and psychiatric assessments, admission and discharge summaries, progress notes, etc., as necessary, in order to determine my acceptance, and continued eligibility, to Sara Riel Inc. for the provision of services.
- Sara Riel Inc. may also be required to share certain information with their funding agents (Government of Manitoba and Winnipeg Regional Health Authority) in the ongoing provision of services.
- My confidential information may be shared with the proper emergency services, if Sara Riel Inc. has justifiable reason to believe that maintaining confidentiality may result in serious threat to the health and safety of me and/or another person.
- My confidential information may be shared with the proper emergency services, if I am incapacitated and/or unable to provide information required to ensure that I receive appropriate care.
- Sara Riel Inc. staff are bound by confidentiality agreements as part of their condition of employment, and may only use my information to provide services to me as I have agreed.
- I may revoke my authorization to share my private information with any and all of the "persons or organizations listed herein"*, at any time, by way of a written 'notice of change'.

BY SIGNING THIS DECLARATION BELOW, I AUTHORIZE…

- Sara Riel Inc. to release my intent to receiving supports from Sara Riel Inc., and to request necessary information regarding my application from the "persons or organizations listed herein"*.
- The release of the requested information from the "persons or organizations listed herein"*, to Sara Riel Inc., for the purpose of receiving supports from Sara Riel Inc.

BY SIGNING THIS DECLARATION BELOW…

- I attest that I am the full age of majority.
- I release Sara Riel Inc., including its employees, agents, students, researchers and volunteers, from any and all claims whatsoever which may arise as a result of the release of information.
- I ensure that all of the information provided in this application is accurate to the best of my ability.

Name *(please print)* ____________________ Date of Birth *(mm/dd/yyyy)* ____/____/______

Signature ____________________ Date Signed *(mm/dd/yyyy)* ____/____/______

"persons or organizations listed herein" *refers to those persons and/or organizations which I have listed on Page 8: Key Service Providers, as well as on Page 3: Referral Source.*

Sara Riel Inc.

Employees of Sara Riel Inc. are bound by confidentiality agreements in accordance with their Service Purchase Agreements to deliver services on behalf of the Winnipeg Regional Health Authority and the Government of Manitoba. The information that applicants supply within the *"Sara Riel Inc. – Application for Services"* is held as privileged, and subject to confidentiality that ensures information is used only in the provision of care to clients, and prohibits unauthorized disclosure pursuant to the *Personal Health Information Act* (PHIA).

Information sharing with third party resources is conducted only with the express and signed approval of the applicant. A detailed *"Authorization for Release of Information"* is supplied on Pages 8 and 9 of this form. It allows the applicant to authorize the release of information to and from specific Key Service Providers. Please read the *"Authorization for Release of Information"* carefully, and sign and date as part of your application.

The information requested herein, has allowed Sara Riel Inc. to streamline the intake and admissions process. It avoids duplication as much as possible, and has eliminated the need for individuals to "tell your story" to more than one staff prior to being accepted into our service programs. This has greatly lessened the potential for individuals to feel like they are being shuffled from person-to-person, in order to assess their needs.

Our hope is that this *"Sara Riel inc. – Application for Services"* is both user-friendly and easy to complete.

Should you have any difficulties completing the application form, please contact the Sara Riel Inc. Intake Worker at (204) 237-7165.

Attending a Sara Riel Inc. – Services Orientation may also be of assistance. Aside from detailed information on all of our services, we have staff available to help you understand or complete your Application for Services.

Services Orientations are held every second Thursday, 10:00am – 12:00pm. To register for a session, contact the Intake Worker at (204) 237-7165.