

# Application for Services

## Sara Riel Inc.

66 Moore Avenue

Winnipeg, Manitoba

R2M 2C4

Intake Direct Line: 204-237-7165

Intake Fax: 204-233-2564

Revised: April 2017



### **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.



**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**

**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

**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)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Issues of Abuse             | <input type="checkbox"/> Addictions Management     | <input type="checkbox"/> Crisis Intervention  |
| <input type="checkbox"/> Family/Supports             | <input type="checkbox"/> Conflict/Anger Management | <input type="checkbox"/> Coping/Self Esteem   |
| <input type="checkbox"/> Dealing with Grief and Loss | <input type="checkbox"/> Medication Management     | <input type="checkbox"/> Psychiatric Concerns |
| <input type="checkbox"/> Physical/Health Needs       | <input type="checkbox"/> Spiritual Needs           | <input type="checkbox"/> Legal Issues/Rights  |
| <input type="checkbox"/> Sexuality/Relationships     | <input type="checkbox"/> Thoughts of Suicide       |   |

\_\_\_\_\_ **COMMUNITY MENTORSHIP** (Independent Living Skills Development)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Housekeeping/Maintenance | <input type="checkbox"/> Financial/Budgeting           | <input type="checkbox"/> Nutrition/Food Preparation |
| <input type="checkbox"/> Social Networking        | <input type="checkbox"/> Personal Self Care            | <input type="checkbox"/> Safety and Security        |
| <input type="checkbox"/> Communication Skills     | <input type="checkbox"/> Transportation/Accessibility. |   |

\_\_\_\_\_ **EMPLOYMENT SERVICES**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Supported Job Search           | <input type="checkbox"/> Career Coaching        | <input type="checkbox"/> Education Planning |
| <input type="checkbox"/> Pre-Employment Skills Training | <input type="checkbox"/> Employment Counselling |   |

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

**HEALTH INFORMATION**

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adjustment Disorder             | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Post-Traumatic Stress Disorder             |
| <input type="checkbox"/> Anxiety Disorder                | <input type="checkbox"/> Eating Disorder               | <input type="checkbox"/> Psychosis <i>(not otherwise specified)</i> |
| <input type="checkbox"/> Attachment Disorder             | <input type="checkbox"/> Obsessive/Compulsive Disorder | <input type="checkbox"/> Schizo-Affective Disorder                  |
| <input type="checkbox"/> Bipolar Disorder                | <input type="checkbox"/> Panic Disorder                | <input type="checkbox"/> Schizophrenia                              |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Personality Disorder          | <input type="checkbox"/> Social Phobia                              |

Other *(please identify and explain)*: \_\_\_\_\_

**Is there a Concurrent Diagnosis of a Developmental Disorder?**

Yes     No

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Autism Spectrum/Asperger's | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Fetal Alcohol Spectrum |
| <input type="checkbox"/> Brain Injury               | <input type="checkbox"/> Dementia            |   |

*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)*

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

**ADDICTION**

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

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol  | <input type="checkbox"/> Prescription Drugs   |
| <input type="checkbox"/> Non-prescription (Street) Drugs                    | <input type="checkbox"/> Solvents <i>(gasoline, glue, paint thinner, )</i>                        |
| <input type="checkbox"/> Shopping <i>(excessive or compulsive spending)</i> | <input type="checkbox"/> Gambling/Gaming  |
| <input type="checkbox"/> Technology <i>(internet/video-gaming)</i>          | <input type="checkbox"/> Food <i>(binging/purging; eating other than out of hunger/nutrition)</i> |

*Please list any specific prescription and non-prescription drugs* \_\_\_\_\_

\_\_\_\_\_

**LEGAL**

**Please indicate any legal involvement:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Certificate of Leave         | <input type="checkbox"/> Order of Committeeship | <input type="checkbox"/> Power of Attorney |
| <input type="checkbox"/> On Parole                    | <input type="checkbox"/> On Probation           | <input type="checkbox"/> Public Trustee    |
| <input type="checkbox"/> Child Custody Order          | <input type="checkbox"/> Order of Recognizance  | <input type="checkbox"/> Prevention Order  |
| <input type="checkbox"/> Restraining Order            | <input type="checkbox"/> Peace Bond             | <input type="checkbox"/> Protection Order  |
| <input type="checkbox"/> Other (please specify) _____ |   |  |

**Please indicate any involvement with the Criminal Justice System:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Current involvement? | <input type="checkbox"/> Criminal record? | <input type="checkbox"/> Incarcerated in past 3 years? |
|---|---|--|

**Convictions:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physical assault             | <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Weapons offence(s) |
| <input type="checkbox"/> Other (please specify) _____ |   |   |

**EDUCATION, EMPLOYMENT AND INCOME**

**Please indicate your highest level of education completed:**

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> High School/GED              | <input type="checkbox"/> Trade School | <input type="checkbox"/> College/University |
| <input type="checkbox"/> Other (please specify) _____ |                                       |   |

**Please indicate your current employment status**

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Unemployed                   | <input type="checkbox"/> Employed ( ___ Full-Time ___ Part-Time ___ Casual ___ Seasonal) |                                    |
| <input type="checkbox"/> Self-Employed                | <input type="checkbox"/> Retired   | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Other (please specify) _____ |  |                                    |

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

- |   |   |
|---|---|
| <input type="checkbox"/> Employment                           | <input type="checkbox"/> CPP Disability                     |
| <input type="checkbox"/> Savings                              | <input type="checkbox"/> Guaranteed Income Supplement (GIS) |
| <input type="checkbox"/> Family                               | <input type="checkbox"/> Old Age Security (OAS)             |
| <input type="checkbox"/> Employment Insurance (EI)            | <input type="checkbox"/> Other Pension                      |
| <input type="checkbox"/> Employment & Income Assistance (EIA) | <input type="checkbox"/> Shelter Benefit/Rent Aid           |
| <input type="checkbox"/> EIA Disability                       | <input type="checkbox"/> Private Insurance                  |
| <input type="checkbox"/> Canada Pension Plan (CPP)            | <input type="checkbox"/> Portable Housing Benefit (PHB)     |
| <input type="checkbox"/> 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
_____ Klinik 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):** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

**KEY SERVICE PROVIDERS – CONTACT INFORMATION AND AUTHORIZATION**

**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.



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**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.

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