Vocational Rehabilitation Services

Manitoba

Family Services and Housing

# APPLICATION

| Applicant Identification | | |
|---|---|---|
| Name (last name, first name, middle name) | | Birthdate (month/day/year) |
| Address | | Phone # |
| SEX male ☐ female ☐ | Canadian Citizen yes ☐ no ☐ | Marital Status |
| SIN | MB Health Reg. # | PHIN |
| Next of Kin (name/address/phone #) | | |
| Treaty Status yes ☐ no ☐ | Band Name and No. | |

| Medical | | | | | | |
|---|---|---|---|---|---|---|
| Physical Health | good | | fair | | poor | |
| Epilepsy | controlled | | uncontrolled | | | |
| Vision | glasses | yes ☐ no ☐ | | | | |
| Hearing | | | | | | |
| Other | | | | | | |
| Medications (list) | | | | | | |
| Allergies (list) | | | | | | |
| Family Doctor (name, phone #) | | | | | | |
| Psychologist (name, phone #) | | | | | | |
| Psychiatrist (name, phone #) | | | | | | |

| Living Situation (check one or more) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Alone | | Family | | Relatives | | Hotel | |
| Apartment | | House | | Room and Board | | Other | |

| Other Agency Involvement or Counselling | |
|---|---|
| yes ☐ no ☐ | |
| What agency? | |
| Counsellor and phone # | |

| Financial Situation (check one or more) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Self Supporting | | Relatives | | Prov. Income Assist. | | UIC | |
| Disability Insurance | | CPP | | City Welfare | | Other | |

## Education

| | | | | | |
|---|---|---|---|---|---|
| Highest level of education attained | | | | | |
| School/training facility attending | | | | | |
| Program enrolled in: | Regular university entrance | | General | | |
| | Modified | | Life Skills | | |
| | Community College | | University | | |
| | Other training facility | | Apprenticeship | | |
| | Other | | | | |
| Please specify diploma/certificate: | | | | | |

## Experience Gained Through Training, Volunteer Work or Employment

Pick the skill areas from the lists below that best match your skills. In each area, show how you got your skills by picking one or more of the following codes:

W - Worked in skill area
Y - Skills acquired through volunteer work, hobbies or personal interest
C - Certificate
D - Diploma
P - Partial Certificate/Training
A - Apprenticed

| Skill Areas | | Skill Areas | | Skill Areas | | Skill Areas | |
|---|---|---|---|---|---|---|---|
| Accountant | | Cooking | | Hairdresser | | Paralegal | |
| Accounting Clerk | | Customer Service | | Heavy Equipment Operator | | Plumbing/Gas/Pipefitting | |
| Assembly/Electric | | Delivery/Courier | | Home Support Worker | | Sales Representative | |
| Assembly/Mechanical | | Dental Assistant | | Kitchen Help | | Security Guard | |
| Auto Body | | Drafting | | Machine Operator | | Sewing | |
| Baker | | Electrical | | Machinist | | Sheet Metal Worker | |
| Bookkeeping | | Electronics | | Maintenance | | Ship/Receive/Warehouse | |
| Butcher | | Farmer/Farm Helper | | Masonry | | Teacher/Teacher's Aide | |
| Carpentry/Cabinet Making | | Fishing - Commercial | | Metal Forming | | Teller | |
| Cashier | | Food & Beverage Service | | Metal/Woodwork | | Trades Helper | |
| Child Care | | Food Counter Attendant | | Motor Vehicle Mechanics | | Trapping | |
| Cleaner | | Forestry/Logging | | Nursing (any medical) | | Truck Driver | |
| Clerical | | General Labour | | Nutrition/Dietary Aide | | Upholstery | |
| Computer Operator | | Graphic Arts | | Painter | | Welder | |
| Computer Programmer | | | | | | | |
| Valid MB Driver's Licence | | Driver's Licence Class | | Clear Driving Record | | Vehicle Available | |

Language spoken or written (list):

Other skills:

## Hobbies/Interests

List:

## Eligibility Conditions and Information

In order to be eligible to receive vocational rehabilitation services within Family Services and Housing, the applicant must meet the following medical eligibility conditions:

1. Live with one of the following disabilities:
   * mental disability
   * learning disability
   * psychiatric disability

2. Have the disability substantiated in writing and signed:
   * by a licensed psychiatrist in the case of a psychiatric disability;
   * by a registered psychologist in the case of a learning or mental disability (or a person working for government in a "psychologist" position and exempt from registration under The Psychologists Registration Act).

NOTE: A medical doctor may sign the diagnosis if the doctor is managing a client who has been diagnosed by a psychiatrist or psychologist.

| | | | |
|---|---|---|---|
| Have you ever been tested by a psychologist or psychiatrist? | yes ☐ no ☐ | what year? | |
| If yes, name of psychologist or psychiatrist | | | |
| Address and phone number | | | |
| If not tested, are you willing to undergo testing? | | yes ☐ no ☐ | |

## Other

| | |
|---|---|
| Is family/guardian/support network in agreement with referral to Vocational Rehabilitation Services program? | yes ☐ no ☐ |

PLEASE ATTACH REQUIRED REPORTS:

1. Psychological report re intelligence, aptitude, interest, etc.
2. Social History
3. Vocational testing or training reports.
4. Educational reports, work experience reports.
5. Psychiatric information (including diagnosis and medication information)
6. Medical information re physical condition pertinent for rehabilitation.

_____ Date _____

Agency/School Signature

_____ Date of Application _____

Client Signature

| FOR OFFICE USE ONLY | | | | |
|---|---|---|---|---|
| Date application received | | | Referral acknowledgement | yes☐ no☐ |
| Voc. Rehab. signature | | | | Date: |
| Disability | | Mental disability (Community Living) | | yes☐ no☐ |
| | | Mental disability | | yes☐ no☐ |
| | | Learning disability | | yes☐ no☐ |
| | | Psychiatric | | yes☐ no☐ |
| Eligibility | yes☐ no☐ | Supervisor Signature | | Date: |
| If no Voc. Rehab. Worker, draft letter rejecting eligibility for Supervisor's signature | | | | yes☐ no☐ |
| Register - Vocational Rehabilitation Services | | | | yes☐ no☐ |

Central Registry #_____; Region #_____; D.O.#_____; Assigned Worker:_____

# REFERRAL FOR E.A.P.D.

NAME IN FULL: _____

ADDRESS: _____

_____ PHONE#: _____ P.C.:_____

D.O.B. _____ SEX: _____ Marital Status: _____

S.A.#: _____ M.H.S.C.#: _____ S.I.N.#: _____

TREATY#: _____ ORDER OF SUPERVISION: _____

SOURCE OF FINANCIAL SUPPORT: _____

LIVING ARRANGEMENTS: HOME____ RM & BRD____ FOSTER HOME____ OTHER____

MOTHER'S NAME: _____ FATHER'S NAME:_____

IN CASE OF EMERGENCY, CONTACT: NAME:_____ PHONE#:_____

ADDRESS: _____ RELATIONSHIP:_____

MEDICAL:

DIAGNOSIS:

_____

MEDICATIONS & REASONS: _____

_____

PHYSICIAN: _____ ADDRESS: _____ PHONE#:_____

PSYCHIATRIST/
PSYCHOLOGIST: _____ ADDRESS:_____ PHONE#:_____

HOSPITAL, CLINICS, ETC. ATTENDED: NATURE OF ILLNESS: DATES:_____

_____

_____

_____

NOTE: WRITTEN CONFIRMATION OF THE ABOVE DIAGNOSIS PERTINENT TO REHABILITATION IS REQUIRED FROM ONE OR MORE OF THE ABOVE IN ORDER TO COMPLETE REFERRAL.

GENERAL HEALTH:

1) PHYSICAL HEALTH IS: POOR _____ FAIR _____ GOOD _____ EPILEPSY: _____

2) SEIZURES: CONTROLLED:_____ UNCONTROLLED:_____

3) SPEECH: _____

4) VISION: NO DEFECTS _____ DEFECTS _____ CORRECTED _____ NOT TESTED _____

5) HEARING: NO DEFECTS _____ DEFECTS _____ CORRECTED _____ NOT TESTED _____

6) DATE OF LAST PHYSICAL EXAMINATION:_____

7) OTHER MEDICAL/PHYSICAL PROBLEMS:_____

_____

_____

_____

OTHER AGENCY INVOLVEMENT:

| NAME | ADDRESS | PHONE | INVOLVEMENT |
|---|---|---|---|

_____

_____

_____

WHAT PROBLEMS DOES THE CLIENT HAVE IN RELATION TO:

FAMILY:_____

_____

COMMUNITY:_____

_____

SELF:_____

_____

CLIENT'S HOBBIES INCLUDE:_____

_____

EDUCATION:

SCHOOLS ATTENDED DATES GRADE/LEVEL ATTAINED

PROBLEMS RELATED TO SCHOOLING:

DID THE CLIENT HAVE A SCHOOL WORK EXPERIENCE: YES____ NO____

WORK EXPERIENCE HISTORY:

EMPLOYER DATES WORKED OCCUPATION/DUTIES REASON FOR TERMINATION

VOCATIONAL GOAL:

LEGAL HISTORY:

IS THERE OR HAS THERE BEEN INVOLVEMENT WITH THE LAW? IF SO, PLEASE DESCRIBE:

MODE OF TRANSPORTATION (IE. SPECIAL SUPPORTS OR TRAVEL INDEPENDENTLY):____

AGENCY INFORMATION:

REASON FOR AGENCY INVOLVEMENT:

REASON FOR REFERRAL:

OTHER SERVICES PRESENTLY OR PREVIOUSLY INVOLVED:

CASE MANAGER:

CLIENT'S PRESENT SITUATION:_____

_____

_____

IS YOUR CLIENT SUFFICIENTLY FIT TO HANDLE FULL TIME TRAINING:_____

_____

IS YOUR CLIENT AWARE OF OUR SERVICES?_____

HAS YOUR CLIENT EXPRESSED A POSITIVE INTEREST IN VOCATIONAL TRAINING LEADING TO COMPETITIVE EMPLOYMENT AND IF SO, HOW?_____

_____

IS THE CLIENT'S FAMILY, GUARDIANS, OR OTHER SUPPORT SYSTEMS IN AGREEMENT WITH A REFERRAL TO VOCATIONAL REHABILITATION SERVICES?_____

_____

OTHER COMMENTS (RE: IMPRESSIONS OF CLIENT):_____

_____

_____

_____

_____

_____

REFERRAL AGENT:_____

ADDRESS:_____

POSITION:_____

TELEPHONE #:_____

PLEASE ATTACH REQUIRED REPORTS:

1. Psychological report re intelligence, aptitude, interest, etc.
2. Social History.
3. Vocational testing or training reports.
4. Educational reports, work experience reports.
5. Psychiatric information (including diagnosis and medication information
6. Medical information re physical condition pertinent for rehabilitation.

DATE:_____ SIGNATURE:_____

**V.R.S. USE ONLY:**

**PSYCHOLOGICAL TESTING/PSYCHIATRIC REPORTS:** _____

**NAME OF TESTING AGENCY:** _____

**DATE OF TESTS:** _____

**COPY ON FILE:** **YES** _____ **NO** _____

**RESULTS:** _____

_____

_____

_____

**VOCATIONAL PLAN:** _____

_____

_____

_____

_____

_____

_____