Society For Manitobans With Disabilities
REQUEST FOR SERVICE FORM

Please Fill-In Bubbles ● Erase Errors Completely. *Print* Neatly Inside Boxes. ***THANKS!!***

1) Date of Request ***(DD/MM/YYYY)*** ☐☐ / ☐☐ / ☐☐☐☐

2) Referred by: ______________ Position (If applicable): ______________

2.1) Telephone Number: (☐☐☐) ☐☐☐ - ☐☐☐☐

3) Name of Organization/Agency making referral? ***(If referred by self/friend/family, please indicate. If Self-Referral, go to Question 6.)***

____

4) Location of Referral Source: ○ Central ○ Eastman ○ Interlake ○ Norman ○ Parkland ○ Westman ○ Winnipeg

5) Postal Code of Referral Source: ☐☐☐ ☐☐☐

6) Name: ***(First, Mid. Init. Last)***

7) Other Name(s) *(If Applic.)*

8) Individual's Date of Birth ***(DD/MM/YYYY)*** ☐☐ / ☐☐ / ☐☐☐☐

9) Individual's Gender: ○ Female ○ Male

10) Address:

10.1) City:

10.2) Province: ☐☐

10.3) Postal Code: ☐☐☐ ☐☐☐

11) Telephone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

11.1) Additional Telephone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

12) Alternate Contact Info.

13) Address:

13.1) City:

13.2) Province: ☐☐

13.3) Postal Code: ☐☐☐ ☐☐☐

14) Telephone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

34435

15) Who does the child live with?

15.1) Relationship to the child? ***(Please fill-in ALL that apply.)***
○ Parent/Guardian ○ Other Family ○ Foster Parent ○ Public Trustee ○ Other

15.2) Is CFS involved? ○ Yes ○ No ○ Don't Know (***If 'No' or 'Don't Know,' please go to Question 16.1.)***

15.3) Nature of CFS involvement? ○ Perm. Ward ○ Temp. Ward ○ VPA ○ Other

15.4) Name of CFS Worker:

15.5) Name of CFS Agency:

15.6) Worker's Phone No. ( ) -

16.1) Diagnosis/Condition (1) ○ Self-Diag. ○ Medical Diag.

16.2) Diagnosis/Condition (2) ○ Self-Diag. ○ Medical Diag.

16.3) Diagnosis/Condition (3) ○ Self-Diag. ○ Medical Diag.

16.4) Diagnosis/Condition (4) ○ Self-Diag. ○ Medical Diag.

16.5) Diagnosis/Condition (5) ○ Self-Diag. ○ Medical Diag.

16.6) Has medical verification been received by SMD on any of these diagnoses/conditions? ○ Yes ○ No

16.7) Additional related comments (eg. functional limitations, etc.)

17) Can the individual communicate in ***English***? ○ Yes ○ No ○ Don't Know ***(If 'Yes,' please go to Question 21.)***

18) Does the individual require an ***Interpreter***? ○ Yes ○ No ○ Don't Know ***(If 'No,' please go to Question 21.)***

19) In what languages does the individual fluently speak/communicate? ***(Please fill-in ALL that apply.)***

○ 1 Albanian	○ 7 Chinese	○ 13 Farsi	○ 19 Khosa	○ 25 Ojibway	○ 31 Somali	○ 37 Vietnamese
○ 2 Amharic	○ 8 Cree	○ 14 French	○ 20 Korean	○ 26 Portuguese	○ 32 Spanish	○ 38 Other
○ 3 Arabic	○ 9 Creole	○ 15 German	○ 21 Kru	○ 27 Punjabi	○ 33 Swahili	
○ 4 ASL	○ 10 Dari	○ 16 Hindi	○ 22 Laotion	○ 28 Russian	○ 34 Tagalog	
○ 5 Bosnian	○ 11 Dene	○ 17 Italian	○ 23 Lebanese	○ 29 Saulteaux	○ 35 Tigrini	
○ 6 Cantonese	○ 12 Dinka	○ 18 Japanese	○ 24 Mandarin	○ 30 Serbian	○ 36 Turkish	

20.1) Please enter the number of the ***primary language of choice*** of the ***family***, from ***Question 19*** above.

20.2) Please enter the number of the ***primary language of choice*** of the ***individual being referred***.

34435

21) What specific services are being requested for this individual from SMD, at this time?

_____

_____

_____

_____

PLEASE NOTE: **Questions 22 and 23 are answered only when a participant is seeking services from *Ethnocultural Services*. All other SMD programs will answer these questions on the *Participant Intake Form Part One*.**

22) Is the individual receiving services from another organization or department? ○ Yes ○ No ○ Don't Know

22.1) If 'Yes,' from which agencies, organization(s) or department(s) is this individual receiving services?

_____

_____

23) Other Agencies, Organizations and/or Departments ***(Taken from Question 22.1, Code List One.)***

24) If request is being made by a representative of an agency, organization or department, is the individual aware that this request is being made on his/her behalf? ○ Yes ○ No ○ Don't Know

25) If the individual is aware that the request for service is being made, is he/she in agreement with this request? ○ Yes ○ No ○ Don't Know

Individual's Signature, if applicable: _____ Date Signed: _____

Signature of person completing this form: _____ Date Signed: _____

34435

SMD USE ONLY

26) Referral Source(s) ***(Code List One)*** ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐

27 Individual's Diagnoses/Conditions ***(Code List Two)***

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☐ ☐☐☐.☐ ☐ ☐☐☐.☐ ☐ ☐☐☐.☐ ☐ ☐☐☐.☐

28) **Outcome of this Request for Service**: ***(Please fill-in ALL that apply.)***

- ○ Individual referred to SMD service ***(Please fill-in bubble, and then go to Question 29.)***
- ○ Individual referred to external service or program ***(From Code List One)***

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- ○ Non-return of forms (Process stopped)
- ○ Individual did not access offered services (Services declined)
- ○ Individual ineligible for SMD services (Please state reason) ☐
- ○ Individual has left catchment area
- ○ Other outcome (Please state) ☐

29) SMD Program(s) to which individual is *internally* referred ***(Please fill-in ALL that apply.)***

1) SMD Children's Services

- ○ Children's Case Management
- ○ Communication Center for Children
- ○ POTC
- ○ Children Leisure and Recreation
- ○ Other Children's ☐

2) SMD Adult Services

- ○ Adult Case Management VR General
- ○ Adult Case Management VR Deaf
- ○ Adult Leisure and Recreation
- ○ TSEP
- ○ MIIP for Newcomers
- ○ Living With Hearing Loss
- ○ Other Adult ☐

3) Other SMD Services

- ○ Wheelchair Services WRHA
- ○ Wheelchair Services Other
- ○ Disabled Parking Permits
- ○ Ethnocultural Services (Children)
- ○ Ethnocultural Services (Adults)
- ○ ASL Immersion Courses
- ○ Other ☐

30) SMD Participant Code, if assigned: ☐☐☐☐☐☐☐☐

31) Please indicate (in MINUTES) the ***approximate*** time used to determine this individual's eligibility to receive SMD services, and the decision regarding which program(s) to internally or externally refer the individual to, if applicable.

Meeting/talking directly with individual/family member	☐☐☐	Accompanying ind. to meetings	☐☐☐	Assisting Ind. to Complete Forms	☐☐☐
Meeting/talking with service providers/referral source	☐☐☐	Translating/ Interpreting	☐☐☐	Driving to/from Meetings	☐☐☐
Undertaking research re. Individual's condn/needs	☐☐☐	Completing Forms/Docs.	☐☐☐	Other Activities	☐☐☐

32) Signature of SMD employee completing this form: _____ 33) SMD Empl. No. ☐☐☐☐

34) Supervisor's signature, if applicable: _____

35) Date on which the outcome of this request was determined: ☐☐ / ☐☐ / ☐☐☐☐

34435