Referral and Intake Application

Children's disABILITY Services

Manitoba Families

This form is available in alternate formats upon request

A referral must be completed to determine eligibility for Children's disABILITY Services. A referral may be completed by the child's parent or guardian, an agency or an individual that supports the family; however, the family must be aware of this referral.

A referral must include:

- This referral form completed in full
- Diagnostic assessment(s) attached

Incomplete referrals may be returned to referral source.

Eligibility Criteria

- Be under 18 years of age
- Resident of Manitoba living with their natural, extended or adopted family, or with legal guardian*
- Present with one of the following:
  - developmental delay
  - autism spectrum disorder
  - intellectual disability
  - lifelong physical disability with significant functional limitation in mobility
  - a high probability of developmental delay

* Children in the guardianship of a Child and Family Services agency who would otherwise be eligible for Children's disABILITY Services may access early intervention services only

A. Child Information

Last Name:	First Name:
Date of Birth (dd month yyyy):	Gender:
Home Address	Mailing Address
Previous Children's disABILITY Services involvement?: ☐ Yes ☐ No	

B. Parent/Guardian Information

☐ Parent ☐ Guardian ☐ Foster Parent	☐ Parent ☐ Guardian ☐ Foster Parent
Name:	Name:
Home Address	Home Address
Mailing Address	Mailing Address
Primary Phone:	Primary Phone:
Secondary Phone:	Secondary Phone:
E-mail:	E-mail:
Language(s) spoken in home: Primary: Other:	Language(s) spoken in home: Primary: Other:
☐ French Service Request ☐ Interpreter Needed	☐ French Service Request ☐ Interpreter Needed

C. Child and Family Services Agency (if applicable)

Name of Authority and Agency:	Name of Case Manager/ Social Worker:
Office Address:	
City:	Postal Code:

D. Professional Diagnostic Assessment

Diagnosis

Please check all of the appropriate categories:

- ☐ Autism Spectrum Disorder
- ☐ Developmental delay DQ: _____ (be specific)
- ☐ Intellectual disability IQ: _____(be specific)
- ☐ Lifelong physical disability with significant functional limitations in mobility
- ☐ Diagnosis of Down Syndrome (Trisomy 21); Prader-Willi Syndrome; Rett Syndrome; WAGR Syndrome; Angelman Syndrome; Leigh Syndrome; Cri-Du-Chat Syndrome
- ☐ Diagnosis with a high probability of developmental delay
- ☐ Lifelong, extreme, complex medical needs (URIS Group A) **in combination with one or more of the above criteria**

☐ Professional report or diagnostic assessment from a qualified professional to make diagnoses relevant to their scope of practice attached.

***Note**:* All assessment information is strictly confidential and resides in Children's disABILITY Services.

E. Parental/Guardian Agreement

Is the family/guardian in agreement with this referral? ☐ Yes ☐ No

F. Referral Source

☐ Parent ☐ Guardian ☐ Agency ☐ Other

Name of Source/Agency:		Name and Designation of Referral Source:
Office Address:		
City:	Postal Code:	Phone:
Signature of Referral Source:		Date:

Comments (if any):

Information on the Collection of Personal Information and Personal Health Information

Personal information and personal health information collected in this application will be used to determine eligibility for Children's disABILITY Services and to plan and deliver services to those enrolled in the program. Collection, use and disclosure of this information is done under the authority of the applicable legislation (The Freedom of Information and Protection of Privacy Act, The Personal Health Information Act, and The Protecting and Supporting Children (Information Sharing) Act).

If you have questions about Children's disABILITY Services' collection and use of your personal information and personal health information, please contact Family Support Services at 204-945-8311.

Manitoba Families

Voluntary Indigenous Identity Declaration

The personal information collected in this section will be used to help the Department of Families understand the composition of Indigenous applicants/participants of the Children's disABILITY Services program.

Providing this information is entirely voluntary.

Which best describes the applicant's Indigenous identity? Please select all that apply:

First Nations ☐

Inuit ☐

Métis ☐

If First Nations, please select all that apply:

Anishinaabeg (Ojibwe) ☐

Anishininewuk ☐

Dakota Oyate ☐

Denesuline (Dene) ☐

Nehethowuk (Cree) ☐

Other ☐ Please specify: _____

If the applicant is a member of a First Nation:

Registration No.: _____

Registry Group No. and Name: _____

Declarant Information

I understand that completing this section is optional and I am providing this information on a voluntary basis. I understand that the Department of Families may collect, use and disclose this information in accordance with applicable privacy laws to help plan, deliver and improve the Children's disABILITY Services program.

Name: _____ Relationship to applicant: _____

Date: _____

Send completed forms along with diagnostic assessment or medical report to:

Fax, Mail or Drop-Off
(all regions)

Family Support Services
SSCY Centre
1155 Notre Dame Avenue
Winnipeg, MB R3E 3G1
Phone: 204-945-8311
Fax: 204-948-4788

Drop-Off Only

EASTERN Region
Morden
290 North Railway Street

Portage la Prairie
25 Tupper Street North

Beausejour
20-1st Street South

Steinbach
242-323 Main Street

NORTHERN REGION
Selkirk
101 – 446 Main Street

The Pas
79 3rd Street Avenue

Thompson
59 Elizabeth Drive

Flin Flon
102-143 Main Street

Swan River
1431 First St. North

WESTERN REGION
Brandon
229-340 9th Street

Dauphin
309–27 2nd Avenue SW