

## Referral and Intake Application

Children's disABILITY Services

**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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another Gender
Address/Postal Code:	
Previous Children's disABILITY Services involvement?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

### B. Parent/Guardian Information

<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent
Name:	Name:
Address/Postal Code: (if different from child)	Address/Postal Code: (if different from child)
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: _____
<input type="checkbox"/> French Service Request <input type="checkbox"/> Interpreter Needed	<input type="checkbox"/> French Service Request <input type="checkbox"/> 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 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 any questions about the collection and use of your information by Children's disABILITY Services, please contact Family Support Services at 204-945-8311.

### 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) ☐

Anishinewuk ☐

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: \_\_\_\_\_

**Please send completed forms along with the diagnostic assessment or medical report to:**

### **WINNIPEG OFFICE**

#### **FAMILY SUPPORT SERVICES**

##### **SSCY Centre**

1155 Notre Dame Avenue  
Winnipeg, MB R3E 3G1  
Phone: 204-945-8311  
Fax: 204-948-4788

### **REGIONAL OFFICES**

#### **EASTERN REGION**

##### **Regional Office**

290 North Railway Street  
Morden, MB R6M 1S7  
Phone: 204-822-2861  
Fax: 204-822-2879  
Toll Free: 1-888-310-0568

##### **Area Office**

25 Tupper Street North  
Portage la Prairie, MB R1N 3K1  
Phone: 204-239-3092  
Fax: 204-239-3198  
Toll Free: 1-866-513-2185

##### **Regional Office**

Box 50, 20-1st Street South  
Beausejour, MB R0E 0C0  
Phone: 204-268-6028  
Fax: 204-268-6222  
Toll Free: 1-866-576-8546

##### **Area Office**

242-323 Main Street  
Steinbach, MB R5G 1Z2  
Phone: 204-346-6390  
Fax: 204-326-9948  
Toll-Free: 1-866-682-9782

#### **WESTERN REGION**

##### **Regional Office**

229-340, – 9th Street  
Brandon, MB R7A 6C2  
Phone: 204-726-6336  
Fax: 204-726-6539  
Toll Free: 1-866-726-6438

##### **Area Office**

309–27, 2nd Avenue SW  
Dauphin, MB R7N 3E5  
Phone: 204-622-2035  
Fax: 204-638-3278  
Toll-Free: 1-866-355-3494

#### **NORTHERN**

##### **Regional Office**

101 – 446 Main Street  
Selkirk, MB R1A 1V7  
Phone: 204-785-5106  
Fax: 204-785-5321  
Toll-Free: 1-866-475-2015

##### **Regional Office**

Provincial Building  
Box 2550, 79 3rd Street Avenue  
The Pas, MB R9A 1M4  
Phone: 204-627-8311  
Fax: 204-627-8265  
Toll-Free: 1-866-443-2292

##### **Area Office**

Box 5, 59 Elizabeth Drive  
Thompson, MB R8N 1X4  
Phone: 204-677-6570  
Fax: 204-677-6517  
Toll-Free: 1-866-677-6713  
Toll-Free: 1-866-443-2291

##### **Area Office**

102-143 Main Street  
Flin Flon, MB R8A 1K2  
Phone: 204-687-1700  
Fax: 204-687-1708  
Toll-Free: 1-866-443-2291

##### **Area Office**

PO Box 997  
1431 First St. North.  
Swan River, MB R0L 1Z0  
Phone: 204-734-3491  
Fax: 204-734-5615  
Toll-Free: 1-866-269-6498