# Application for Services

**Sara Riel Inc. provides community-based supports to persons who experience issues with mental illness or mental health challenges including substance use disorders and addictions.**

Please fill out and return this application to Sara Riel by faxing, mailing, or dropping it off at our office. Need help filling out your application? Contact our Intake/Discharge Coordinator at 204-237-7165.

## Personal Information:

First Name: _____ Last Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone #: _____ Email: _____

## Demographic Information:

Date of Birth (mm/dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___ Preferred Service Language: ☐ English ☐ French

Gender Identity: _____ Pronouns: _____

Select all that apply to you that you feel comfortable sharing:

| | | |
|---|---|---|
| ☐ First Nations | ☐ Landed Immigrant | ☐ I am on Employment & Income Assistance (EIA) |
| ☐ Métis | ☐ Refugee | ☐ I am on Manitoba Supports for Persons with Disabilities (MSPD) |
| ☐ Inuit | ☐ 2SLGBTQ+ | ☐ _____ |

## Service Request - Please check off the service you would like to receive (one service per applicant):

☐ Mental Health Case Management
☐ Community Mentorship (Independent Living Skills Development)
☐ Employment Services

## Mental Health Information

Please indicate your mental health diagnosis and/or current mental health/addiction concern:

_____

Please indicate any concurrent diagnosis or developmental disorder:

_____

*Autism Spectrum Disorder, Learning Disability, Brain Injury, Dementia, Fetal Alcohol Spectrum Disorder (FASD)*

## Who referred you to Sara Riel?

Name: _____ Title: _____

Organization: _____



101-66 Moore Avenue, Winnipeg, MB R2M 2C4 | 204-237-7165 | info@sararielinc.com | sarariel.ca

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# Application for Services – continued

**This part of the application only needs to be filled out if you would like to apply to Seneca Respite.**

### Seneca Respite Service Request:

☐ I would like to apply for access to Seneca Respite

### Mental Health Professional Contact Information

Let us know who to contact to get documentation for your application to Seneca Respite Services.

Name: _____

Group/Organization: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone #: _____ Fax #: _____

Email: _____

**For this application, we can accept documentation from: addictions agencies, medical practitioners, clinical social workers, mental health agencies, Crisis Stabilization Unit/Crisis Response Center Clinicians, nurse practitioners, hospital/psychiatric units, psychologists, Klinic Social Workers, or psychiatrists. Collateral is obtained to receive Seneca Respite services. See consent below.*

### 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 information necessary to determine my acceptance, and continued eligibility, to Sara Riel Inc. for the provision of services.
- 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 at any time, by way of a written notice of change.
- Sara Riel Inc. has the "Duty to Report". If life or safety is seriously threatened, disclosure is required by law. This "Duty to Report" supersedes all confidentiality and authorizations.

**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 above.
- The release of the requested information from the persons or organizations listed above 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 knowledge and ability.

Name (please print): _____ Signature: _____

Date (mm/dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___



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