St.Amant

Application/Inquiry Form
Community Services
Foster Services/Home Share

St.Amant
Central Intake
440 River Road
Winnipeg, MB, R2M 3Z9
Phone: 204-258-7041
Fax: 204-258-7066
Email: intake@stamant.ca

Application Completed By:	
Name:	
Relationship to Person:	
Contact Information:	
Date:	

This application is for ☐ Foster Services ☐ Home Share

Information about Person

Demographic Information			
Legal Last Name (Surname):			
Legal First Name:			
Legal Middle Names:			
Preferred Name(s):			
Date of Birth:			
Personal Health Identification Number (9 Digit PHIN):			
Manitoba Registration Number (6 Digit):			
Social Insurance Number:			
Social Allowance Number (for Children):			
Gender Identity:		Pronouns:	
We celebrate diversity and strive to make St.Amant inclusive for everyone. Please let us know the applicant's name, which pronouns to use, and if they change. Answers should reflect what the applicant declares themselves to be, not what a care provider assumes.			
Treaty or INAC # and Band Information:			
Current Address:	Street or box #		
	City		
	Province		
	Postal Code		
Mailing/Permanent Address (if different from above):	Street or box #		
	City		
	Province		
	Postal Code		
Primary Phone #		Secondary Phone #	
Okay to leave message? ☐ yes ☐ no		Okay to leave message? ☐ yes ☐ no	
Email:			

Race, Ethnicity, and Indigenous Identity Data

St.Amant collects this information to help understand and close gaps in health care access, experience, and outcomes. These questions are voluntary and participation will not impact care or services. Answers are protected under *The Personal Health Information Act* (PHIA). Answers should reflect what the applicant declares themselves to be, not what a care provider assumes.

Optional: Does applicant identify as First Nations, Inuk/Inuit, and/or Métis? Check all that apply.	☐ First Nation Status ☐ First Nation Non-Status ☐ First Nation (do not know status) ☐ First Nation (prefer not to disclose status)	☐ Inuit ☐ Métis ☐ Not Indigenous ☐ Do not know ☐ Prefer not to answer ☐ Other:

Optional: What ethnicities does the applicant identify as? List all that apply.	

Communication Information

Primary Language:		Interpreter Required?	☐ yes ☐ no
Would applicant like access to service in French?	☐ yes ☐ no		

Health and Function

Mobility:	☐ Ambulant (walking) ☐ Power Wheelchair ☐ Manual Wheelchair ☐ Other:
Vision:	☐ Functional ☐ Impairment ☐ Visual Aides
Hearing:	☐ Functional ☐ Hearing Loss (Aided) ☐ Hearing Loss (Unaided)

Legal Status of Applicant

Does this person make their own decisions about health care/treatment? If no, please describe their legal representative/decision maker below.	☐ yes ☐ no

☐ Child: parent(s) are legal guardians
☐ Child: other legal guardian (please describe)
☐ Adult: Committee
  ☐ Personal
  ☐ Property
☐ Adult: Substitute Decision Maker appointed under ALIDA (formerly VPA)
  ☐ Personal
  ☐ Property

Guardian/Decision Maker Information (if applicable). Please list all.				
Name:				
Relationship to applicant/decision making status:				
Agency Name:				
Current Address:	Street or box #			
	City			
	Province			
	Postal Code			
Primary Phone #			Secondary Phone #	
Okay to leave message? ☐yes ☐no			Okay to leave message? ☐yes ☐no	
Fax:				
Email:				
Name:				
Relationship to applicant/decision making status:				
Agency Name:				
Current Address:	Street or box #			
	City			
	Province			
	Postal Code			
Primary Phone #			Secondary Phone #	
Okay to leave message? ☐yes ☐no			Okay to leave message? ☐yes ☐no	
Fax:				
Email:				

Referral Awareness We ask these questions in the spirit of person-centered care. The answers below will not impact the decision to accept or decline the referral.	
Is the applicant aware of this referral?	☐yes ☐no ☐n/a
Is the applicant's family aware of this referral?	☐yes ☐no ☐n/a
Is the decision maker (if other than family) aware of this referral?	☐yes ☐no ☐n/a
Do all parties support this referral?	☐yes ☐no ☐n/a

Supports Intensity Scale (SIS) Level (if applicable):	
CFS Funding Level (if applicable):	

Service Worker Information (CdS, CLdS, CFS, etc.)	
Name:	
Primary Phone #	

Medical Information	
Diagnoses/Disabilities:	
Please comment on this person's health:	
Please describe the type of assistance and support this person requires throughout their day:	
Please describe the ideal residential service for this person (where would it be located, would they live with someone else, staffing patterns/models, type of housing, qualifications of staff, etc.):	
Please comment on the desired timeline for obtaining residential supports (is this an immediate need, would like an option in two years, etc.):	
Please describe this person's current living situation:	
Please describe what types of supports have been explored in the past for this person:	
Please describe what this person does during the day (school, work, recreation/leisure, day service, etc.):	
Please comment on this person's preferred lifestyle (does this person like to be busy all the time, are they a homebody, are they very social, etc.):	
Is there any other information you wish to share? Any risks or vulnerabilities that may impact someone's ability to live independently?	