POST MAJORITY SUPPOR SERVICES INTAKE FORM
MANITOBA KEEWATINOWI OKIMAKANAK INC

CLIENT INFORMATION	
First Name:	**Last Name:**
Date of Birth (mm/dd/yyyy):	**Gender:** ☐ **M** ☐ **F** ☐ **X**
Registered: ☐ **Y** ☐ **N** **If yes, registration number & band.**	
Health (MHSC / PHIN)	
Phone:	**Email:**
Preferred method of contact:	

EDUCATION	
School:	**Highest level completed:**
University or College:	**Certificate/Degree completed:** ☐ **Y** ☐ **N**

CHILD AND FAMILY AGENCY	
Agency:	
Case Worker:	**Address:**
City/Town:	**Postal Code:**
Phone:	**Email:**

REASON FOR INTAKE

SIGNATURE	
Print Name:	**Signature:**
Verbal Consent:	**Date of Verbal Consent:**
PMSS Staff Name:	**PMSS Staff Signature:**
Date (mm/dd/yyyy):	

ENROLLMENT CONSENT

I _____ consent to my enrollment in the Post Majority Support Services program to access financial, educational & development, housing, relationship building, culture & spirituality, health & wellbeing, advocacy & rights, and emerging adulthood development services and supports, including assessment and, potentially treatment. The general risks and benefits of enrolling in the Post Majority Support Services program have been explained to me. I understand that discussions regarding risks and benefits will continue over the course of enrollment. I understand that I have the right to ask questions about service and participate in goal setting and clinical planning. My participation in treatment will be interpreted as ongoing consent. I understand that I can withdraw consent for this service at any time. I understand that doing so would in no way affect my ability to access service in the future.

SIGNATURE	
Print Name:	**Signature:**
Verbal Consent:	**Date of Verbal Consent:**
PMSS Staff Name:	**PMSS Staff Signature:**
Date (mm/dd/yyyy):	

INFORMATION EXCHANGE CONSENT

SECTION 1. CONSENT TO SHARING OF INFORMATION

I understand that some personal information and/or personal health information may need to be shared for the purpose of assessment, treatment, planning and developing programs and/or strategies that will benefit the individual. I understand that personal information or personal health information is disclosed in order to act in the best interest of the person. I understand that the information shared will be on a need-to-know basis only.

The Personal Health Information Act (PHIA) and the Protecting and Supporting Children (Information Sharing) Act allow service providers to share personal information and/or personal health information with other service providers without consent in certain circumstances. I understand that personal information and/or personal health information may be shared without my consent for the purpose of providing timely and necessary servicers or care.

I understand that each of the participating organizations/agencies listed in Section 2 will maintain confidentiality of the information in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA), the Privacy Act, the Access to Information Act, the Personal Information Protection and Electronic Document Act (PIPEDA) and any other applicable legislation. I understand that person(s) not authorized under the Act(s) and who wish to receive information, or a copy of a report, are required to obtain consent from the individual or their authorized legal representative or legal guardian.

I _____ consent to the sharing of my personal information and/or personal health information between organizations/agencies listed in section 2. I understand that I can withdraw this consent at any time. I understand that doing so would in no way affect my ability to access services in the future.

INFORMATION EXCHANGE CONSENT (CONTINUED)

My personal information and/or personal health information may be shared with the following:

ORGANIZATION/AGENCY	
Contact person:	
Phone:	**Email:**

INDIVIDUAL	
Contact person:	
Phone:	**Email:**

My personal information and/or personal health information ***MAY NOT*** be shared with the following:

ORGANIZATION/AGENCY	
Contact person:	
Phone:	**Email:**

INDIVIDUAL	
Contact person:	
Phone:	**Email:**

SIGNATURE	
Print Name:	**Please Sign:**
Verbal Consent:	**Date of Verbal Consent:**
PMSS Staff Name:	**PMSS Staff Signature:**
DATE (mm/dd/yyyy):	