



## INTAKE FORM

### FAMILY INFORMATION

#### Guardians Legal Name

LAST: \_\_\_\_\_

GIVEN: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

#### Address

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

Primary Caregiver's Family Code (F/L/M/D/Y): \_\_\_\_\_

### HOUSEHOLD MEMBERS

NAME:	BIRTH DATE:	RELATIONSHIP:

### IN CASE OF EMERGENCY

CONTACT PERSON: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_

# INTAKE FORM

## OTHER AGENCIES WORKING WITH FAMILY

DATE KNOWN:	AGENCY NAME:	CONTACT PERSON:	TELEPHONE:	DATE SERVICES TERMINATED:

## PARTICIPANTS CODES (Use Primary Caregivers Initials and Date of Birth)

MEMBERS:	FIRST INITIAL:	LAST INITIAL:	MONTH:	DAY:	YEAR:	CODE:
<b>Mother</b>						<b>01</b>
<b>Father</b>						<b>02</b>
<b>Other</b>						<b>03</b>
<b>Child</b>						<b>04</b>
<b>Child</b>						<b>05</b>
<b>Child</b>						<b>06</b>
<b>Child</b>						<b>07</b>

I acknowledge that this information will be held in strict confidence and available to me during normal program hours. I will advise the CFA Program of any changes to this information as soon as possible.

Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_



## CLIENTS UNDERSTANDING OF CFA POLICY ON CONFIDENTIALITY

In order to protect the rights and privileges of individual staff members, all staff shall exercise confidentiality with respect to information of a personal or financial nature, or internal business matters of the program. Any breach of confidentiality may result in immediate dismissal.

All files are confidential and are protected by the Personal Information Protection and Electronic Documents Act (PIPEDA).

CFA Staff Operates as a team to provide you with the best service possible. You may deal with more than one staff person (all who are bound by the same confidential policy). This means staff may need to share information (with your knowledge) in order to better meet your needs.

We will not give out personal information about you to other agencies/organizations without your consent except to protect life or safety when we are required to do so by law.

I have read and discussed this information with CFA Program. I have a good understanding of CFA/ANA policy on confidentiality.

Participants Name: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Primary Caregiver Code: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_



## WAIVER FORM

I, the undersigned, hereby release the Aankaanotamagewin Services, from any liability or responsibility whatsoever the injury, illness, or other damage which I may receive while participating in any Aankaanotamagewin Service sponsored events, workshops, and/or presentations.

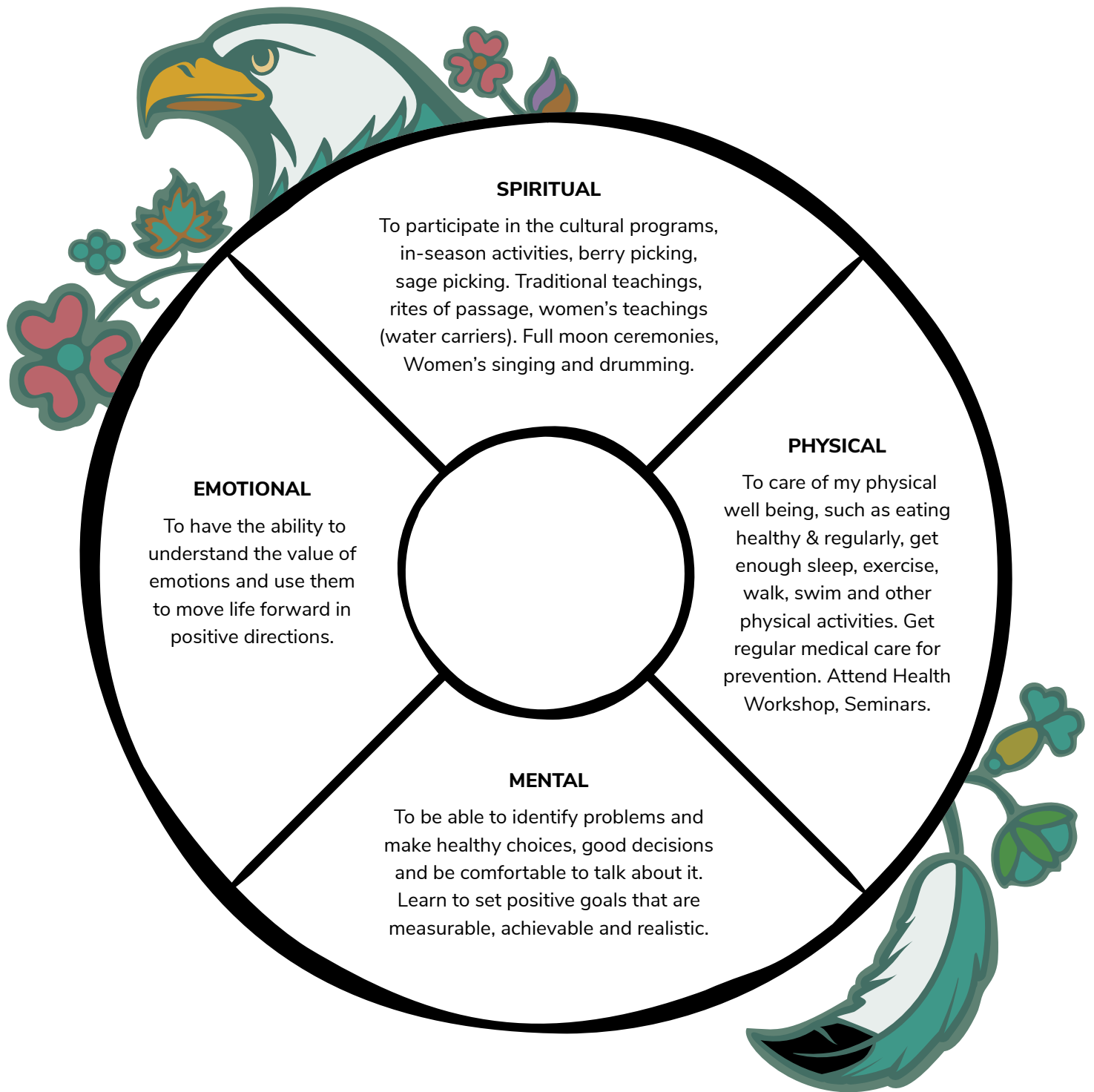
Client signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

Guardian signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

Signature CFA: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_



## PLAN OF CARE



**Example Only**

Family Name: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_



## HOLISTIC HEALTH & THE FOUR DIRECTIONS

The **Physical** dimension of child wellness deals with the functional operation of the body. In general, wellness factors related to the physical dimension can be grouped within the following categories:

- ▶ Physical Activity including motor development, adequate amounts of sleep, body weight
- ▶ Nutrition including a balanced diet and access to healthy food
- ▶ Medical Care including updated immunizations and pre/post natal checkups, and access to medical system when needed
- ▶ Physical Environment including safety in the home, preventing common injury and avoiding pollution (e.g. environmental tobacco smoke, bacteria or contaminated water)

The **Mental** dimension deals with cognitive development and use of language.

Wellness factors related to the mental dimensions include the child's ability to pay attention, problem solves and understanding concepts. Communication and use of expressive language including gestures, sounds and words also contribute to mental wellness. The use of observation as a learning process is key for developing the mental aspects of Aboriginal children. Children learn through observation.

The **Emotional** dimension deals with secure attachment, healthy self-confidence and emotional stability. Encouraging emotional development in Aboriginal children helps them define their sense of purpose and the feeling of being grounded in their culture. They develop a sense of who they are and they understand that they matter. Children should feel supported and encouraged to feel their emotions and should be involved in traditional ceremonies, teachings, and use of traditional medicines. Children also need to develop a strong sense of belonging and must have opportunities to feel their connections to family, clan, nation and creation.

The **Spiritual** dimension deals with the child's connection to their inner self and all that is. When children are born, their spirits are pure, clean and complete; it is at this time they are most connected to the spirit world. Wellness factors include praying, learning or hearing traditional songs, the sound of the drum, participating in cultural ceremonies, knowing their language and understanding their connection and relationship to self, family, nation, land, animals and the spirit world.



## PLAN OF CARE

DATE: \_\_\_\_\_ FAMILY: \_\_\_\_\_

NOTES:

### SUPPORT PLAN

PHYSICAL:

MENTAL:

EMOTIONAL:

SPIRITUAL:



## WORKSHOPS/TRAINING

Please check all the areas of interest or the types of services requested

Adult Crafts	Family Violence	Parenting Skills
Blood Monitoring	Food Banks	Post Natal Care
Children's Crafts	Friendship/end to isolation	Prenatal Care
Client Advocacy	HIV/AIDS	Recreation Access
Client Referral	Hospital Visit	Self Care Services
Counseling	Improve Basic Need	Shelter
Cultural Teachings	Membership Services	Soup Kitchen
Elder Home Visits	Parental Support	Used Clothing
Employment Services	Elder	Volunteering

### COMMUNITY EDUCATION WORKSHOPS / PRESENTATIONS

Alcohol Abuse	Drug Abuse	Nutrition
Bicycle Safety	Elder Abuse	Nutritional
Home Safety	Eye Care	ONWA Programs
Responsible Gambling	FAS/E	Physical Activity
Budgeting	First Aid	Self Care
Bullying	Foot Care	Smoking
Cancer	Healthy Sexuality	Stress Management
Community Development	Dental Hygiene	Fire Safety
Cultural Teachings	Heart Disease	Environmental
Diabetes	Hepatitis C	Suicide Intervention
HIV/AIDS	Life Skills	WHIMIS





## RELEASE OF INFORMATION

I hereby give informed consent and authorization to the Aankaanotamage'win Services to request/release information regarding;

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

From/to the following individual/agency:

NAME: \_\_\_\_\_

### PURPOSE

In the best interests of your family, Aankaanotamage'win Services needs to obtain relevant information from outside agencies or individuals in order to have full understandings of your family's history and needs. A full understanding is needed to conduct an accurate assessment of your family, and to develop a comprehensive individual program plan. Such information allows coordination of our work with other agencies involved, thus avoiding duplication. Any information obtained is treated as strictly confidential and is not released to or discussed with any other person(s) or agency(ies). Aankaanotamage'win Services information is released with only your expressed written consent. Careful consideration is given to what the information will be used for and to whom this information is being sent.

Date (mm/dd/yy): \_\_\_\_\_

Parent/Guardian/Client Name (please print): \_\_\_\_\_

Parent/Guardian/Client Signature: \_\_\_\_\_

CFA Worker Signature: \_\_\_\_\_



## REFERRAL FORM

DATE: \_\_\_\_\_

### AGENCY REFERRAL

#### Name

FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ LAST: \_\_\_\_\_

#### Address

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX: \_\_\_\_\_

#### Date Of Birth

MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_ YEAR: \_\_\_\_\_

Aboriginal Ancestry:  Status  Non Status

Band Name if Applicable: \_\_\_\_\_

### REASON FOR REFERRAL

REFERRED BY: \_\_\_\_\_

PHONE: \_\_\_\_\_



## PHOTO RELEASE

In consideration for value received, receipt whereof is acknowledged, I hereby give The Aaskaanotamagewin Services for my images, in whole or in part, captured during regular and special Aaskaanotamagewin Services activities through video, photo and digital camera, to be used solely for the purposes of Aaskaanotamagewin Services promotional material and publications, and waive any rights of compensation or ownership there to.

Date (mm/dd/yy): \_\_\_\_\_

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

If the person photographed is under 18, I certify that I am his or her Parent or legal guardian and I give my consent without reservation to the foregoing on his or her behalf.

Date (mm/dd/yy): \_\_\_\_\_

Name of participant (please print): \_\_\_\_\_

Name of Parent/Guardian (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Participant signature: \_\_\_\_\_



# Grassy Narrows Child and Family Advocates

## CLIENT SUPPORTS

PRIMARY CAREGIVER CODE: \_\_\_\_\_

**Client Supports** for the purpose of a **Home Visit**.

**Please list supports provided:**

Participant Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

CFA Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_