BCANDS REQUEST FOR SERVICES FORM

In order to assist you and provide the services you require to meet your needs it is necessary for us to collect personal information. We would like to assure you that the information we collect, use and may disclose, with your consent, is protected under the Personal Information Protection Act. If you have any questions or concerns about the collection, use or disclosure of your personal information please mention this to the BCANDS case worker or you can contact the 'Office of the Information & Privacy Commissioner'.

PLEASE LET US KNOW IF YOU NEED HELP WITH FILLING OUT THIS FORM.
We can be contacted toll free at 1-888-815-8800 or 250-381-7303

PERSONAL INFORMATION

LAST NAME	**GENDER**	**Traditional Name** (optional)	**Date of Birth: (YYYY/ MM /DD)**
	☐ Male ☐ Female ☐ Other Identity	Would you like us to use your traditional name? Yes____ No____	/ /
FIRST / MIDDLE NAME			**Name of Parent/Guardian** (if applicable)

ANCESTRY (please check one):

- ☐ First Nation Status
- ☐ Status Number _____
- ☐ First Nation Non-Status
- ☐ Métis Citizen
- ☐ Citizenship Number _____
- ☐ Métis Citizen Pending
- ☐ Inuit

Nation: _____

Client location (please check one):

- ☐ On-reserve / First Nations Community
- ☐ Off-reserve / Urban

Social Insurance Number: (Optional):

Personal Health Number (Care Card):

CONTACT:
Telephone: _____

Telephone: _____

Email: _____

CLIENT ADDRESS (Note name of facility if applicable)
Street Address line 1

Street Address line 2

City/Town

Province

Postal Code

**** PLEASE NOTE SIGNATURES ARE REQUIRED ON PAGES 4 AND 5 ****

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Name of contact person or person completing this form, if different from information listed above.

First Name: _____ Last Name: _____

Organization / Position (if applicable): _____

Address of contact person or person completing this form, if different from information listed above.

Street Address: _____

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

DISABILITY - Please provide a brief description of the nature of your disability. If extra space is needed, feel free to add extra pages.

REQUESTED BCANDS SERVICES - Please provide a brief description on how BCANDS can assist you.

BCANDS partners with post-secondary educational facilities (college and/or university level), where practicum students of Social Work and other programs work with us to serve our clients. Please check off if you give permission for practicum students to work with you and BCANDS staff with your request for services.

☐ Yes, I allow practicum students to help BCANDS staff in my request for services.
☐ No, I do not wish to have practicum students involved in my request for services at this time.
☐ Not sure, please explain the details to me, so that I fully understand.

FOR STAFF USE ONLY. In the case client selected "Not sure" to the use of practicum students:

☐ I have explained and client understands and **gives permission** to the use of practicum students.
☐ I have explained and the client understands and **does <u>not</u> give permission** in the use of practicum students.

BCANDS Limits of Confidentiality and Release of Information Form

LIMITS OF CONFIDENTIALITY

The contents of an intake or assessment session are considered to be confidential. Both verbal information and written records about you cannot be shared with another party without your written consent or the consent of a legal guardian. It is the policy of the B.C. Aboriginal Network on Disability Society (BCANDS) not to release any information about you without a signed release of information. Noted exceptions are as follows:

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouses records.

PROFESSIONAL MISCONDUCT

Professional misconduct by a health professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

COURT ORDERS

Health Care professionals are required to release records of clients when a court order had been placed.

MINORS/GUARDIANSHIP

Parents of legal guardians of non-emancipated minor clients have the right to access the clients' records.

BCANDS Limits of Confidentiality and Release of Information Form

OTHER PROVISIONS

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible services and support. In such cases your name, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In the event the BCANDS must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the Society or the nature of the call, but rather the worker's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to you (or guardian) without identifying the name of the Society. If the person answering the phone asks for more identifying information we will say that it is a personal call.

We will not identify the Society (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY TELEPHONE.
Include phone numbers and how you would like us to identify ourselves when phoning you.

Check if Yes		**Phone Number**	**How should we identify ourselves?**	**May we say the Society's (BCANDS) name?** YES	NO
Home					
Cell					
Work					
Other					

By signing below **I agree to the above LIMITS OF CONFIDENTIALITY** and understand their meanings and ramifications.

→ _____ _____ _____

Client's Name (please print) **Client's (or Guardian's) Signature** **Date**

→ _____ _____ _____

Witness Name (please print) **Witness Signature** **Date**

BCANDS Limits of Confidentiality and Release of Information Form

B.C. Aboriginal Network on Disability Society (BCANDS)
#6 – 1610 Island Hwy, Victoria, British Columbia V9B 1H8
Telephone: 250-381-7303 Fax: 250-381-7312 Toll Free: 1-888-815-5511

RELEASE OF INFORMATION FORM

This form has been developed to comply with the Personal Information ***Protection Act, S.B.C. 2003, c. 63*** to ensure confidentiality and to make provisions for the exchange of relevant personal and service-related information between service providers.

As part of the process of assisting you in your health needs, BCANDS employees will collect information pertaining to you and your situation. BCANDS uses this information to understand your needs in order to best serve you. In some instances, **BCANDS staff may require to consult / confer with referring agencies or other related service providers while we work with you in regard to your health needs.**

Additionally, BCANDS may collect general statistical information about our clients or Nations for a variety of reasons. These include; reports to funding agencies, research projects and public relations. This statistical information never contains identifiable information.

If you agree to allow BCANDS to use your information in this manner, please complete the following:

→ I, _____ Date of Birth: _____
Please print first and last name

hereby authorize the release of information to the employees of the B.C. Aboriginal Network on Disability Society, and further, authorize them to release information from my file as necessary, while assisting me with my health needs. I understand that information will only be shared as necessary for the provision of services, and that I may revoke this consent at any time, either verbally or in writing.

→ _____ _____
Client (Guardian) Signature Date

→ _____ _____
Witness Signature Date