



## British Columbia Aboriginal Network on Disability Society (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 and Society policy. If you any questions or concerns about the collection, use or disclosure of your personal information please mention this the Disability Case Manager 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: 1-888-815-5511 or 250-381-7303 or by email at [dcm3@bcands.bc.ca](mailto:dcm3@bcands.bc.ca)

#### PERSONAL INFORMATION

<b>Last Name</b>	<b>Gender</b>  <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Identity	<b>Preferred / Traditional Name</b> (optional)  Would you like us to use this name? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Date of Birth:</b>
<b>First and Middle Name</b>			<b>Name of Parent/Guardian</b>

  

<b>Ancestry:</b> <input type="checkbox"/> First Nation Status Status Number _____ <input type="checkbox"/> First Nation Non-Status <input type="checkbox"/> Métis Citizen Citizenship Number _____ <input type="checkbox"/> Métis Citizen Pending <input type="checkbox"/> Inuit  <b>Nation:</b> _____  <b>Client location:</b> <input type="checkbox"/> On-reserve <input type="checkbox"/> Off-reserve / Urban  <b>Social Insurance Number: (Optional):</b>  <b>Personal Health Number (Care Card):</b>	<b>Contact:</b>  Telephone: _____  Cellular Telephone: _____  Telephone: _____  Email: _____  Additional Information: _____  <b>Residence / Mailing Address</b> (Note name of facility if applicable) Street Address line 1 _____ Street Address Line 2 _____ City / Town and Province _____ Postal Code: _____
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**\*\*\* PLEASE NOTE THAT SIGNATURES ARE REQUIRED ON PAGES 4 AND 5**



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**Name of contact person or person completeing this form, if different from information listed on page 1.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Organization / Position / Relationship to Applicant (as applicable): \_\_\_\_\_

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

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

City / Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

### DISABILITY CONDITION

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

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### Use of Practicum Students

\* BCANDS partners with various educational facilities for the provision of practicum Social Work and other students to assist in the delivery of BCANDS programs and services. Please indicate your preference in regard to allowing practicum students to assist BCANDS team members with your request for services.

- ☐ Yes, I authorize the use of practicum students to assist BCANDS team members 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 BCANDS STAFF USE ONLY. In the case the applicant selected "not Sure" to the use of practicum students:**

- ☐ I have explained and the applicant understands and **give permission** to the use of practicum students. .
- ☐ I have explained and the applicant understands and **does not give permission** to 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 spouse's 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	May we say the Society's (BCANDS) name?		If no, how should we identify ourselves?
		YES	NO	
Home				
Cell				
Work				
Other				

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

**\* YOU MUST PRINT YOUR NAME, DATE AND SIGN, AS WELL AS HAVING THE WITNESS SECTION COMPLETED**

→ \_\_\_\_\_  
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.

**\* YOU MUST PRINT YOUR NAME, DATE AND SIGN, AS WELL AS HAVING THE WITNESS SECTION COMPLETED**

→ \_\_\_\_\_  
Client (Guardian) Signature Date

→ \_\_\_\_\_  
Witness Signature Date



**Intake Completed By:** Bailey Moorhouse

**Date Completed:** Click or tap to enter a date.