Ministry of Social Development and Poverty Reduction

Facility/Residence Admittance, Transfer or Discharge

Service Request #:	
Service Provider ID:	

The personal information requested on this form is collected and used by the Ministry of Social Development and Poverty Reduction pursuant to sections 26(c) and 32(b) of the *Freedom of Information and Protection of Privacy Act* for the purpose of administrating the *Employment and Assistance Act* and *Employment and Assistance for Persons with Disabilities Act*. If you have any questions about the collection or use of this information, please contact the Ministry of Social Development and Poverty Reduction at 1-866-866-0800.

◯ Admittance ◯ Transfer	Date (YYYY MMM DD)	***Or***	◯ Discharge	Date (YYYY MMM DD)

Client Information

Last Name	First Name	Initials

Date of Birth (YYYY MMM DD)	Social Insurance Number	PHN Number

Does client's current rental accommodation outside of the facility/residence need to be maintained? If so, provide address below:

Address to be Maintained	Postal Code

Facility/Residence Information

Name	Phone Number	Fax Number

Physical Address	Postal code

Mailing Address if Different than Physical Address	Postal code

Payee

License or Registration Number	
	☐ Not Licensed or Registered

Indicate Facility/Residence Type

Mental Health	☐ Licensed Mental Health - Residential Care	☐ Registered Mental Health - Assisted Living	☐ Mental Health - Family Care Home	☐ Mental Health - Tertiary Residential Care
Substance Use	☐ Licensed Substance Use - Residential Treatment	☐ Registered Substance Use - Assisted Living Supportive Recovery Home		
Community Care	☐ Licensed Community Care - Long Term Care Home	☐ Licensed Community Care - Short Stay - Respite, Hospice, Convalescence	☐ Registered Community Care - Assisted Living	☐ Community Care - Family Care Home

Other Funding / Resources (i.e. Ministry of Health, First Nations Health Authority, or private funding)

Any external funding being paid to cover client stay? ◯ Yes ◯ No

Client Income

Does the client have any income? ◯ Yes ◯ No If yes, please indicate income $ _____ /month and source below:

☐ CPP/CPPD ☐ EI ☐ Employment ☐ Other Income source _____

Note: It is the facility/residence's responsibility to collect and monitor income from the client and apply any other income contributions towards their treatment/per diem costs/user charges on a monthly basis.

Client Signature and Consent

I, _____ hereby authorize the staff from the Ministry of Social Development and Poverty Reduction to obtain and release information from my file required to establish payment of user charges. This includes any income or assets received or pending, and any missing documents that might affect my eligibility.

Client Signature	Date Signed (YYYY MMM DD)

This Section is to be completed by the Ministry Worker

Eligible: ◯ Yes ◯ No	Date of Eligibility (YYYY MMM DD)	Client Contribution per month $	Effective Month

Date (YYYY MMM DD)	Worker Name	Worker's Comments