Ministry of Social Development and Poverty Reduction

ADMITTANCE AND DISCHARGE

SR Number:

The personal information requested on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act*, section 26(c) and is subject to all of the provisions of that Act. The information will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*, to determine eligibility and to make payment for the type of assistance requested. For further information regarding the collection, use and/or disclosure of your personal information, please contact the Ministry of Social Development and Social Innovation office that you receive services from.

INDICATE FACILITY TYPE

☐ Residential Community Care Facility ☐ Residential Mental Health Facility ☐ Residential Substance Use Facility

☐ Assisted Living Community Care Facility ☐ Assisted Living Mental Health Facility ☐ Assisted Living Substance Use Facility, including Registered Supportive Recovery Home

FACILITY INFORMATION

FACILITY NAME	PHONE NUMBER	FAX NUMBER

ADDRESS	POSTAL CODE

FACILITY MANAGER CONTACT INFORMATION

CLIENT INFORMATION

LAST NAME	FIRST NAME	INITIALS

DATE OF BIRTH (YYYY MMM DD)	CASE NUMBER

SOCIAL INSURANCE #	MSP NUMBER	PHN NUMBER

DATE OF ADMITTANCE (YYYY MMM DD)	OR	DATE OF DISCHARGE (YYYY MMM DD)

IS THE CLIENT REQUESTING TRANSPORTATION TO AND/OR FROM AN A & D TREATMENT CENTRE?	IF "YES", WHAT KIND?
YES ☐ NO ☐	

IS THE CLIENT ELIGIBLE FOR COMFORTS FUNDS?	IS ASSISTANCE WITH SHELTER COSTS REQUIRED?	ESTIMATED LENGTH OF TIME THE SHELTER COST ASSISTANCE WILL BE REQUIRED?
YES ☐ NO ☐	YES ☐ NO ☐	

Fax to the Ministry of Social Development and Poverty Reduction at:

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)

****** BOTTOM SECTION TO BE COMPLETED BY MINISTRY WORKER/ UPDATE CLIENT FILE /COPY OF THIS COMPLETED DOCUMENT IS TO BE PROFILED TO ICM AND FAXED TO THE FACILITY ******

The client is required to pay a monthly contribution to the facility in the amount of: **$**

If a monthly contribution applies, it will be paid from the client's: CPP ☐ EI ☐ CPPD ☐ Other ☐

IF OTHER, PLEASE INDICATE INCOME SOURCE:

NOTE: It is the facility's responsibility to collect from the client any other income and apply it as client contribution towards their user charges.

WORKER SIGNATURE	WORKER NAME (PLEASE PRINT)

WORKER'S COMMENTS

PROOF OF INCOME MUST BE ATTACHED TO THE USER CHARGES