MAKOON TRANSITION INC.

Reunification and Prevention Program for Families
107 - 26 Gaylene Place
Winnipeg, MB
R3T 4G7

For further information, please contact.
Makoon Transition Inc. - (204)306-4289 or (204)807-6135
Please email completed application form to intake@makoon.ca

Date:

How did you hear about this program?

Name of person making referral:

Phone Number:

Email Address:

Reason for Referral:

MOTHER'S INFORMATION

Mother's Full Name (First, Middle, and Last Name):

Mother's maiden name (if applicable):

Phone Number:

Address:

Email Address:

Mother's Facebook Profile Name:

Date of Birth:

Treaty Number:

Band Name:

MB Health Card - 6 Digits: 9 Digits:

Marital Status (single, married, separated, divorced, common-law, widowed):

Emergency Contact Name, Phone Number, and Relationship to Contact:

EIA Case Number:

EIA Worker's Name:

CFS Agency:

CFS Worker's Name:

CFS Worker's Phone Number:

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FATHER'S INFORMATION

Father's Full Name (First, Middle, and Last Name):

Phone Number:

Address:

Email Address:

Father's Facebook Profile Name:

Date of Birth:

Treaty Number:

Band Name:

MB Health Card - 6 Digits: 9 Digits:

Emergency Contact Name, Phone Number, and Relationship to Contact:

EIA Case Number:

EIA Worker's Name:

EIA Worker's Phone Number:

CFS Worker's Name:

CFS Worker's Phone Number:

LINEAGE INFORMATION

Maternal Grandmother's Name (Children's Mother's mother):

Date of Birth:

Treaty Number:

Band Name:

Maternal Grandfather's Name (Children's Mother's father):

Date of Birth:

Treaty Number:

Band Name:

Paternal Grandmother's Name (Children's Father's mother):

Date of Birth:

Treaty Number:

Band Name:

Paternal Grandfather's Name (Children's Father's father):

Date of Birth:

Treaty Number:

Band Name:

CHILDREN'S INFORMATION

Name:

Date of Birth: Gender:

Treaty Number:

MB Health Card - 6 Digits: 9 Digits:

Please list any special needs, medical issues, prescription medications, allergies, concerns, or issues:

Name:

Date of Birth: Gender:

Treaty Number:

MB Health Card - 6 Digits: 9 Digits:

Please list any special needs, medical issues, prescription medications, allergies, concerns, or issues:

Name:

Date of Birth: Gender:

Treaty Number:

MB Health Card - 6 Digits: 9 Digits:

Please list any special needs, medical issues, prescription medications, allergies, concerns, or issues:

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Name:

Date of Birth: Gender:

Treaty Number:

MB Health Card - 6 Digits: 9 Digits:

Please list any special needs, medical issues, allergies, prescription medications, concerns, or issues:

Name:

Date of Birth: Gender:

Treaty Number:

MB Health Card - 6 Digits: 9 Digits:

Please list any special needs, medical issues, allergies, prescription medications, concerns, or issues:

When was the last time you used drugs and/or alcohol?

What did last use?

What was your drug of choice?

Do you smoke tobacco or marijuana? If yes to marijuana, is it prescribed?

Do you have any special needs or medical issues, such as Diabetes, HIV, any mental health illness, etc.?

Are you currently on any prescription medication?

If so, please list what you are taking:

Do you have a Criminal Record?

If so, please explain:

Do you have any No Contact Orders in place ?

If so, please list them below:

Please list of programs and supports you are currently involved with:

Please list the programs and supports you have previously been involved with:

Are your children placed with family (Kinship Care)?

If so, please explain :

Have you ever had any previous CFS involvement?

If so, please explain:

What are the goals you would like to achieve while attending our program?

What are your plans for once you have completed our program?

DEPARTMENT OF INDIGENOUS SERVICES CANADA
JORDAN'S PRINCIPLE
Information Sharing Consent

Child Name:	
Parent/Guardian Name:	
Authorized Representative:	

Note: Authorized Representatives (person acting on behalf of Parent/Guardian) also attest to receiving verbal consent from parent/guardian and reviewing privacy notice statement.

Privacy Notice Statement
The personal information you provide is protected in accordance with the Privacy Act and collected under the authority of the Privy Council Order-in-Council PC Number 2017-1464. We require this information to determine eligibility and process requests for health, social and educational assistance under the Jordan's Principle Initiative. Your personal information may be used within the Department of Indigenous Services Canada for the alignment of health, social and educational benefits and for audit purposes. With consent, personal information may be disclosed to health, social and educational services professionals, and service coordinators for processing requests. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. This information collection is described in Info Source, available online at infosource.gc.ca. Your rights under the Privacy Act: You have the right of access to, correction and protection of your personal information. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

I , _____ have read and reviewed the privacy notice above and attest that I agree
(Parent or Authorized Representative)

to the sharing of information with *MAKOON TRANSITION INC.* for the sole purpose of

providing services to the child noted above.

_____ _____
Signature **Date**

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I , _____ have read and reviewed the privacy notice above and attest that I agree
(Parent or Authorized Representative)

to the sharing of information with _____ for the sole purpose
(Name of the involved CFS Agency)

of providing services to the child noted above.

_____ _____
Signature **Date**

DEPARTMENT OF INDIGENOUS SERVICES CANADA
JORDAN'S PRINCIPLE
REQUEST FORM

Please complete this Form to make a request, and send it to the Focal Point in your region.
Please note: If immediate or urgent care is required for a child, please call 911 or your local emergency services number, or visit the nearest health facility.

Please identify if you are a:
◯ Child over 16 years
◯ Parent/Guardian
◯ Authorized Representative of the Parent/Guardian (In order for a representative to make a request on behalf of the parent/guardian, please ensure the parent/guardian gives the representative oral confirmation, the representative then must attest to this confirmation.)

SECTION 1: Child's Information	
Given Name:	Family Name:
Child's Date of Birth (yyyy/mm/dd):	Child's sex: ☐ Female ☐ Male ☐ Unspecified
Address (i.e. civic address, apartment/unit number) :	
City/Community:	Province/Territory:
Postal Code:	Telephone Number:
Does the child live or ordinarily live on reserve: ◯ Yes ◯ No	Is the child in CFS Care: ◯ Yes ◯ No ○ Federal Ward ○ Provincial Ward
Is child registered (Y/N)? If yes, registration number:	If no, name of both parents & registration numbers:

*If parents treaty numbers are not available, please provide DOB(s)

SECTION 2: Parent/Guardian's Information	
Given Name:	Family Name:
Relationship to child:	
Address, if different from above (i.e. civic address, apartment/unit number):	
City:	Province/Territory:
Postal Code:	Language preference:
Telephone number:	Email address:

SECTION 3: Authorized Representative's Information (if applicable)	
Given Name:	Family Name:
Relationship to child:	
Relationship to parent/guardian:	
Address (i.e. civic address, apartment/unit number):	

SECTION 6: Declaration & Signature

I declare the information to be true and accurate and that it does not contain a request for any benefit or service previously paid for by Department of Indigenous Services Canada or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits.

Please identify if you are a:

- ◯ Child over 16 years
- ◯ Parent/Guardian
- ◯ Representative Requestor
  *I confirm that I have received consent

Signature:

Print Name:	**Date (yyyy/mm/dd):**

FOR INTERNAL USE

FOR GOVERNMENT OF CANADA USE ONLY

Request Tracking Number:

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