

# MAKOON TRANSITION INC.

Reunification, Prevention & Long-Term Treatment Program for Families

107 – 26 Gaylene Place

Winnipeg, MB

R3T 4G7

For further information, please contact us at 204-807-6135 or toll-free at 1-833-929-8899.

Please fill out the requested information to the best of your abilities.

If you don't know an answer to a question, leave it blank or write "unknown".

Please email the completed application forms to [intake@makoon.ca](mailto:intake@makoon.ca) or fax them to 204-306-4290.

Date: \_\_\_\_\_

How did you hear about this program? \_\_\_\_\_

Name of the person making this referral: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Do you know any current or former residents of Makoon? If so, please provide their names.

\_\_\_\_\_

## **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: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

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

Emergency Contact Information (*Please include their Name, Phone Number, and Relationship to Mother*):

\_\_\_\_\_

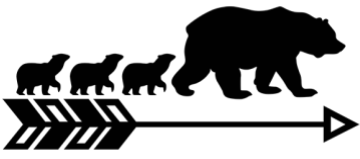
EIA Case Number: \_\_\_\_\_

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: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

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

Emergency Contact Information (*Please include their Name, Phone Number, and Relationship to Father*):  
\_\_\_\_\_

EIA Case Number: \_\_\_\_\_

EIA Worker's Name: \_\_\_\_\_

CFS Agency: \_\_\_\_\_

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 and/or Band Name: \_\_\_\_\_

- Maternal Grandfather's Name (*Children's Mother's Father*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Treaty Number and/or Band Name: \_\_\_\_\_

- Paternal Grandmother's Name (*Children's Father's Mother*): \_\_\_\_\_

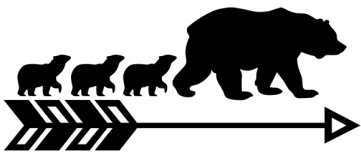
Date of Birth: \_\_\_\_\_

Treaty Number and/or Band Name: \_\_\_\_\_

- Paternal Grandfather's Name (*Children's Father's Father*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Treaty Number and/or Band Name: \_\_\_\_\_



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## CHILDREN'S INFORMATION

Name (*first, middle, and last name*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

Type of Order (*please check one of the following*):

- |   |  |
|---|--|
| <input type="checkbox"/> Apprehension           | <input type="checkbox"/> VPA – Voluntary Placement Agreement       |
| <input type="checkbox"/> TO – Temporary Order   | <input type="checkbox"/> VSG – Voluntary Surrender of Guardianship |
| <input type="checkbox"/> PO – Permanent Order   | <input type="checkbox"/> No CFS Involvement                        |
| <input type="checkbox"/> SO – Supervision Order |  |

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

\_\_\_\_\_

Name (*first, middle, and last name*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

Type of Order (*please check one of the following*):

- |   |  |
|---|--|
| <input type="checkbox"/> Apprehension           | <input type="checkbox"/> VPA – Voluntary Placement Agreement       |
| <input type="checkbox"/> TO – Temporary Order   | <input type="checkbox"/> VSG – Voluntary Surrender of Guardianship |
| <input type="checkbox"/> PO – Permanent Order   | <input type="checkbox"/> No CFS Involvement                        |
| <input type="checkbox"/> SO – Supervision Order |  |

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

\_\_\_\_\_

Name (*first, middle, and last name*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

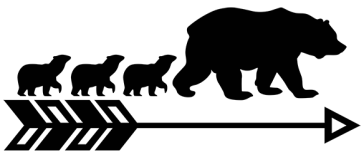
Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

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\_\_\_\_\_



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Name (*first, middle, and last name*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

Type of Order (*please check one of the following*):

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

\_\_\_\_\_

Name (*first, middle, and last name*): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Treaty Number: \_\_\_\_\_

Manitoba Health Card – 6 Digits: \_\_\_\_\_ 9 Digits: \_\_\_\_\_

Type of Order (*please check one of the following*):

- |   |  |
|---|--|
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| <input type="checkbox"/> TO – Temporary Order   | <input type="checkbox"/> VSG – Voluntary Surrender of Guardianship |
| <input type="checkbox"/> PO – Permanent Order   | <input type="checkbox"/> No CFS Involvement                        |
| <input type="checkbox"/> SO – Supervision Order |  |

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

\_\_\_\_\_

Are your children placed with family (Kinship Care)? \_\_\_\_\_

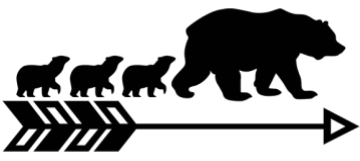
If so, please explain: \_\_\_\_\_

Have you had any previous CFS involvement regarding your children? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Did you have CFS involvement as a child? \_\_\_\_\_

If so, did you age out of care? \_\_\_\_\_



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

What did you 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 (NCOs) in place? \_\_\_\_\_

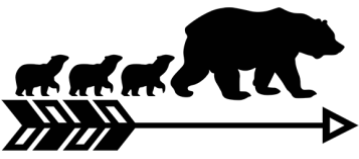
If so, please list them below:  
\_\_\_\_\_

Please list the programs and supports you are currently involved with:  
\_\_\_\_\_

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

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

What are your plans once you have completed our program?  
\_\_\_\_\_



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## CONSENT FOR RELEASE OF INFORMATION – INTAKE FORM

I, \_\_\_\_\_, hereby give my consent to Makoon Transition Inc. and the following Child and Family Services Agency, \_\_\_\_\_, to exchange any and all information, including but not limited to drug test results and social histories pertaining to myself and my children.

Name(s) of Child(ren):

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### **My signature means that:**

- I have read this consent or have had this consent read to me.
- I understand and agree to the contents.
- I have been informed that no other information may be released without my written consent.
- I have been informed that I may revoke this consent by written statement at any time.

**This consent form will remain in effect for 2 years from the date of signature, or until revoked by written notice.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date