Application for Services

Sara Riel Inc. provides community-based supports to people who are 18 years of age or older, are able to attend services in Winnipeg, and want support with mental health and/or addiction challenges.

Please fill out and return this application to Sara Riel by faxing, mailing, or dropping it off at our office. Need help filling out your application? Contact our Intake/Discharge Coordinator at 204-237-7165.

Personal Information (please print clearly)**:**

First Name: _____ Last Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Please write and checkmark your preferred method of contact:

☐ Phone: _____ ☐ Email: _____

☐ Check this box if it's ok to leave a voicemail at the number you gave.

Demographic Information:

Date of Birth (mm/dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___ Service Language: ☐ English ☐ French

Gender Identity: _____ Pronouns: _____

Select all that apply to you that you feel comfortable sharing:

☐ Indigenous	☐ Landed Immigrant	☐ I am on Employment & Income Assistance (EIA)
☐ 2SLGBTQ+	☐ Refugee	☐ I am on Manitoba Supports for Persons with Disabilities (MSPD)

Service Request - Please checkmark the one service you would like to receive:

☐ Community Mentorship (Independent Living Skills Development)
☐ Employment Services
☐ Mental Health Case Management
And/or
☐ Seneca Respite Services (Peer-Supported, 5-Night Stay)

Would you like to receive an application for Sara Riel's Supported Transitional Housing? ☐ Yes ☐ No

To be eligible for Sara Riel's housing program, applicants must: have a diagnosed/documented mental illness, have a history of multiple evictions due to mental health challenges, need regular on-site support, and be willing to engage with support plan and staff.

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2025-09-16

Application for Services – continued

Mental Health Information

Please indicate any diagnosis you have received and/or your mental health/addictions concerns:

_____

Please indicate any concurrent diagnosis or developmental disorder:

_____

Autism Spectrum Disorder, Learning Disability, Brain Injury, Dementia, Fetal Alcohol Spectrum Disorder (FASD)

To access services at Sara Riel we require one or both: a diagnosed mental illness (from a clinical source) or a documented mental health concern (from a non-clinical source). Your options to provide this documentation include:

1. Giving us consent and contact information for a service provider/support worker who can provide this documentation ☐
2. Providing documentation directly (copies of records you have in your possession) ☐
   OR
3. Giving our collateral form to your service provider to fill out and send back to us ☐

Service Provider Contact Information

Let us know who to contact to obtain documentation for your application to our services.

Name: _____

Group/Organization: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone #: _____ Fax #: _____

Email: _____

Who referred you to Sara Riel (e.g.: self, family, friend, social media, or an organization)?

Name: _____ Title: _____

Organization: _____

Have you applied to or received services from Sara Riel in the last 12 months?

☐ No ☐ Yes: _____

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Application for Services – continued

Sara Riel Inc. Authorization for Release of Information

By signing this declaration below, I understand that:

- Sara Riel Inc. may require to both obtain and share information necessary to determine my acceptance, and continued eligibility, to Sara Riel Inc. for the provision of services.
- Sara Riel Inc. staff are bound by confidentiality agreements as part of their condition of employment and may only use my information to provide services to me as I have agreed. I may revoke my authorization to share my private information at any time, by way of a written notice of change.
- Sara Riel Inc. has the "Duty to Report". If life or safety is seriously threatened, disclosure is required by law. This "Duty to Report" supersedes all confidentiality and authorizations.

By signing this declaration below, I authorize:

- Sara Riel Inc. to release my intent to receiving supports from Sara Riel Inc., and to request necessary information regarding my application from the persons or organizations listed above.
- The release of the requested information from the persons or organizations listed above to Sara Riel Inc., for the purpose of receiving supports from Sara Riel Inc.

By signing this declaration below:

- I attest that I am the full age of majority.
- I release Sara Riel Inc., including its employees, agents, students, researchers and volunteers, from any and all claims whatsoever which may arise as a result of the release of information.
- I ensure that all of the information provided in this application is accurate to the best of my knowledge and ability.

Name (please print): _____ Signature: _____

Today's Date (mm/dd/yyyy): ___ ___ / ___ ___ / ___ ___ ___ ___

Service providers assisting in the application process may submit collateral along with this form to expedite the process, provided prior consent is given by the applicant. Fax documentation to (204) 233-2564 or email our Intake/Discharge Coordinator at *intake@sarariel.ca*

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