**Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)**

|  |
| --- |
| Client Information and General Information |
| Last Name |  | First Name |  |
| Phone Number |  | E-mail |  |
| Alias: |  |
| Gender |  | Date of birth (MM/DD/YYYY) |  | Age: |  |
| Do you have any dependents (Y/N)? |  | How many dependents in your care? |  |
| Do you identify or self-identify as Indigenous or other identities?  |  |
| Do you have any income?  |  |

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| --- |
| Are You Experiencing …  |
| Chronic homelessness (experiencing homelessness for at least a year) (Y/N)? How Long? |  | At risk of homelessness (struggling to remain homed) (Y/N)? |  |
| Non-chronic homelessness (currently homeless for less than a year) (Y/N)? How Long? |  | Domestic violence (Y/N)? |  |

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| --- |
| Are You Living with … |
| Physical disability (Y/N)? Please explain. |  |
| Developmental disability (Y/N)? Please explain. |  |
| Struggling with Mental Health (Y/N)? |  |
| Struggling with Addictions (Y/N)? |  |

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| --- |
| Do you need support … |
| With improving employment, education, or training (Y/N)? Please explain. |  |
| To achieve, maintain, or increase income (Y/N)? Please explain.  |  |
| To obtain Housing (Y/N)? |  |
| Getting into detox or treatment? |  |

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| Reasons for Referral |
|  |

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| Additional Information (Barriers, Goals etc.) |
|  |

|  |
| --- |
| Referring Agency Information |
| Agency |  |
| Contact Phone |  |
| Email |  |
| Mailing Address |  |
| Are you referring through ICA, ACM or PSH Consortium? |  |

|  |
| --- |
| Office Use Only |
| Date Reviewed (MM/DD/YYYY) |  |
| Does client meet eligibility requirements? |  |
| Accepted by: |  |
| Denied services (why)? |  |

  **FOIP**

This personal information is being collected under the authority of Section 33c) of the *Freedom of Information and Protection of Privacy ACT* (the “FOIP ACT”) and/or in accordance with any applicable agreements in place. All personal information collected during the registration process, during the course of the client’s stay and for participation in any projects will be used to provide services and ensure a safe and secure environment of all of our clients. It will be treated in accordance with the privacy provision of **PART 2** of the FOIP ACT. Limited information may also be provided to the Minister of Human Services for the purpose of carrying out projects, activates or policies under his administration (e.g. research, statistical analysis) or for receiving provincial and/or federal funding. If you have any questions, contact Shelter Population Support Navigator at 587-612-5356 EXT. 8702.

 **Disclosure of Personal Information**

The Blood Tribe Department of Health’s Lethbridge Wellness Shelter & Stabilization Unit will only use and disclose my individually identifying personal information from my client file to organizations that will help the Shelter Population Support Navigator to obtain resources and supports for me, only with my consent. This consent will automatically expire in 1 year after receiving services for this project or whenever I terminate it. My consent is voluntary and will not result in any adverse decisions about my rights, benefits or services. Other than limiting the ability of organizations to work together on my behalf.