Saskatchewan Cognitive Disability Strategy Renewal Form

Before you start:

1. The application should be completed with the support of your team lead. For more assistance, please visit: ***http://publications.gov.sk.ca/documents/17/ 81137-Cognitive-Disability-StrategyApplication.pdf*** for the contact information for your local Cognitive Disability Strategy Consultant (CDC); then "Frequently Asked Questions" and "Team Lead Role" documents.
2. The renewal must be submitted **3 months prior to expiry**.
3. Incomplete Forms will be returned.

Supports/Services Requested *(Please check all that apply)*

❑ **Consultation to Planning:**	❑ **Behaviour Assessment and Support:**	❑ **Flexible Funding:**
Consultants can provide guidance to help develop/ mentor new teams and teams who are struggling with supporting individuals with complex needs.	Consultants can provide guidance to teams dealing with complex behavioural challenges. Requests for support need to be focused on a specific goal and are time limited.	Flexible funding requests can assist individuals with unmet service needs.

Section 1: Applicant Information

This section collects information about the applicant. The "applicant" is the individual with the cognitive disability.

Date of Renewal: (Click or tap to enter date.)		**Personal Health Number (health card number):** (Click or tap to enter number.)	
Name: (Surname, First Name)		**Is the applicant a Canadian citizen or Permanent Resident of Canada?**	❑ Yes ❑ No
Sex:	❑ M ❑ F ❑ Prefer not to disclose	**Birth date:** (Click or tap to enter a date)	**DLSA** (Click or tap to enter a date)
Constitutional status:	❑ Status Indian ❑ Non-Status Indian ❑ Not Applicable	**Does the applicant live on-reserve?**	❑ Yes ❑ No
Marital status:	❑ Married ❑ Common-Law ❑ Divorced/Widowed ❑ Single	Current living situation:	❑ Independent ❑ Family home ❑ CLSD Approved Private Service Home (APSH) ❑ Other (please specify):

Home Address:	Street, City/Town, Province, Postal code
***Mailing Address** *(Preferred address for correspondence if different from home address.)*	Street, City/Town, Province, Postal code

*** Please note:** *Correspondence will be sent to the applicant's mailing address listed above unless email is the preferred method of communication. Team leads and CDCs will receive e-mail copies of correspondence.*

Please check if you prefer correspondence via email. ❑

Email Address: (Click here to enter text.)	**Phone Number:**

Section 2: Caregiver Information *(if applicable)*

Name: (Surname, First Name)

Phone Number:		**Email Address:**	(Tap here to enter text.)
Marital status *(only applicable to* caregivers caring for children under 18)	❑ Married ❑ Common-Law ❑ Divorced/Widowed ❑ Single	**Relationship to the applicant:**	❑ Parent ❑ Legal guardian ❑ Person with Sufficient Interest ❑ Other (please specify):

Section 3: Financial Information (only for flexible funding requests)

CDS flexible funding is income tested. This means information about the applicant's income is required.

Information about the **household** income is required. For CDS, household income is calculated based on the combined income(s) of adults living in a conjugal (married or common law) relationship in the home. **Each** partner must provide a Notice of Assessment (NOA).
If the applicant is **18 years of age or older**, and is receiving SAP, SIS or SAID, an NOA is not required.
If the applicant is **18 years of age or older** and is **not** receiving SAP, SIS or SAID, the applicant's NOA is required.

Is the applicant (18 or older) or caregiver currently receiving Social Assistance?	❑ No ❑ Yes, please check one of the options below: ❑ Saskatchewan Assured Income for Disability (SAID) ❑ Saskatchewan Assistance Plan (SAP)
Notice of Assessment (NOA) submitted: For applicants 18 years of age and older, who are not receiving SAP, SIS or SAID, an NOA (line 236) is required. For applicants under the age of 18, the caregiver(s) NOA(s) is/are required to assess household income.	❑ Yes (Applicant/Partner #1) ❑ (Partner #2) ❑ No Applicant/Partner 1 Line 236 amount _____ Partner #2 Line 236 amount _____
In addition to the applicant, are there any other individuals with disabilities living in the family home that are eligible for the Federal Disability Tax Credit (DTC)? To find out if you may be eligible for the DTC, please see: ***https://www.canada.ca/en/revenue-agency/services/tax/individuals/segments/tax-credits-deductions-persons-disabilities/disabilitytax-credit.html#lgblt***	❑ No ❑ Yes (Please enter how many individuals qualify in addition to the applicant.)

Section 4: Team Lead and Current Support Team Information

The "Team Lead" is identified as the individual who will be considered as the key contact person for the application. *(See Appendix C for more information.)*

Who is the team lead?	(Surname, First Name)	Agency:	(Click here to enter text.)
Address:	(Street, City/Town, Province, Postal Code)		
Phone Number:		Email Address:	(Click here to enter text.)

Current Support Team Information (Check all that apply):

❑ CDS Consultant:	(Surname, First Name)	Email Address:	(Click here to enter text.)
❑ Teacher:	(Surname, First Name)		
❑ CLSD case worker:	(Surname, First Name)		
❑ Mental Health Counsellor	(Surname, First Name)		
❑ Other	(Surname, First Name)	Agency:	(Click here to enter text.)
❑ Other	(Surname, First Name)	Agency:	(Click here to enter text.)
❑ Other	(Surname, First Name)	Agency:	(Click here to enter text.)
❑ Other	(Surname, First Name)	Agency:	(Click here to enter text.)

Date of team meeting and who was in attendance:

Section 5: Renewal Request Summary

Services Approved Last Year (List each service separately including the approved amount.)	**Funding Amount Spent**	**Identified Goals/Benefits**	**Outcome Indicators** (What worked and did not work?)	**Rationale for Continued Request**
1.				
2.				

Section 6: New Request (This section only needs to be completed for services not included last year and outlined in the previous section.)

LIST SERVICE/ SUPPORT REQUESTED	**RATIONALE** - why is this an unmet need? Explain which system/agency has been approached to provide the services/supports? Identify why each system/agency is not able to provide the support/service being identified. Supporting documentation is required to accompany the application.	**IDENTIFIED BENEFIT/ GOAL SUMMARY** Please identify goals and success measures. How will the service/support be useful in the applicant's day to day life?	**PLAN** List the steps to achieve the identified goals. How will the service/support be set up and monitored through the year to ensure it is of benefit?	**IMPLEMENT/REVIEW** Who will be responsible for implementing and monitoring the plan? List review timelines.

Section 7: **Budget Proposal** (if applicable)

LIST SERVICE/SUPPORT REQUESTED	**DETAILED BUDGET** (e.g. hours, rate of pay, kilometres, etc.)	**ANNUAL COST**
1.		
2.		
3.		
4.		
	Total proposed annual budget request	**Yearly Total** $

Section 8: Consent for Collection, Use and Disclosure of Information

Please initial each box to signify understanding of each statement.

I/Parent or Legal Guardian _____ (name) of _____ (applicant), of _____ (city of residence) consent to officials from the Cognitive Disability Strategy to collect, use and disclose the following types of personal information of the above named individual for the purpose of support planning to meet the needs of the above named individual. I also consent to:

❑ The Application/Renewal/Amendment package, including most recent tax notice of assessment, be released to the intake committee and Cognitive Disability Strategy provincial staff. The intake committee may include the following:

- Cognitive Disability Consultants and their host agency
- Community-Based Organizations
- Regional Education Representatives
- First Nations Organizations
- Community Representative
- Ministry of Justice
- Regional Health Authorities
- Ministry of Social Services
- Elders (if applicable)

❑ The review of the application package to determine if I/my child/dependent is eligible to receive Cognitive Disability Flexible Funding and/or access supports from the Cognitive Disability Strategy

❑ Release of contact information to SaskAbilities or the Daily Living Support Assessment *(flexible funding requests only)*.

❑ My application being submitted to the Ministry of Social Services where they may open a file for payments upon final approval (flexible funding requests only).

❑ My application and the information I provide within being reviewed by the Ministry of Social Services for the purposes of program improvement and the continued development of provincial disability supports.

❑ I understand the Cognitive Disability Strategy may contact Ministry of Social Services to verify information about me/my child related to one or more of the following:

- Information relating to: financial assistance, employment programs, training allowances and benefits, employment assistance for persons with disabilities, career and employment services, seniors' benefits, child care subsidy programs, child care inspections, investigations, licensing, funding or qualifications, individuals with intellectual disabilities and approved private-service home operators (protected under *The Freedom of Information and Protection of Privacy Act*).
- Information relating to: medical reports, doctor's notes or letters and medical assessments (protected under *The Health Information Protection Act*).
- Information pertaining to: Child and Family Services involvements. (Protected under *The Health Information Protection Act* and *The Child and Family Services Act*).

❑ I understand that the Cognitive Disability Strategy and the representatives may contact the supports listed in the application to verify information. However, they will only release as much information as is needed to those individuals in order to process the application.

❑ I can withdraw my consent at any time by writing or talking to my local Cognitive Disability Consultant.

❑ If I withdraw consent, it means "I don't consent from now on." If withdrawing consent, it will mean my application cannot continue and I cannot receive funding or services/supports from the Cognitive Disability Consultant.

- This consent is valid for the term of the funding/service approval period.

If applying for Behavioural Support the following applies:

❑ I understand that the Cognitive Disability Consultant will collect, disclose and use my personal and health information when necessary for the purpose of planning and the development and implementation of behavior support strategies and to meet the obligations of my behaviour support plan. The information may include the following:

- Social history;
- Family history;
- Needs assessment and support plans;
- Employment information;
- Educational, psychological and psychiatric assessment(s) and evaluation(s);
- Medical information, including medical assessments;
- Behavioural descriptions and data;
- Behavioural history, including incident reports and progress notes; and,
- Support plans.

❑ Information may be collected from and disclosed to the following as part of development and implementation of my plan or support strategies:

- Social/medical professionals (e.g. psychologist, counselor, therapist, physician);
- Community service providers/community-based organizations;
- Ministry of Social Services (CLSD/Child and Family Programs/Income Assistance);
- Other Saskatchewan government ministries (e.g. Health, Education, Justice);
- Family/next-of-kin;
- Advocate; and,
- Other members of my planning and support teams.

❑ I understand this information will only be shared as it directly relates to behavioural support planning in the development and delivery of behavioural support. The Cognitive Disability Consultant's host agency is responsible for the security and retention of records related to behavioural support planning and will limit access to only those involved.

❑ I understand that I am agreeing to participate in planning and activities as outlined in my comprehensive behavior support plan to the best of my abilities.

Signature of applicant/parent/guardian	Date
Signature of Witness	Date