CLEAR FORM

Manitoba

Community Living disABILITY Services

ADMISSIONS APPROVAL AND PRIORITIZATION OF FUNDING COMMITTEE – Funding Approval

Part A *– To be completed by CSW/Program Manager/Supervisor*		**Date**	
Participant Name			
Age		**Supports Budget Level Assignment (if available)**	
Primary Disability			
Region		**Community Area (if applicable)**	
CSW			
Program Manager/Supervisor			
Agency/Service Provider			
Requires specialized or wheelchair accessible housing?	Yes ☐ No ☐ Not Available ☐		
Date of last Person-Centred Plan			

CURRENTLY APPROVED FUNDING			
Service Type	Per Diem	Current fiscal Year Cost	Full Year Annualized
Residential Funding			
Day Services			
Transportation			
Drop-In Program			
Enhanced Program Support			
Other (Clinical, etc)			

PROPOSED ADJUSTMENTS TO SERVICES AND COST SUMMARY Please indicate amount of any increase/decrease to the current approved funding			
Service Type	Per Diem	Current fiscal Year Cost	Full Year Annualized
Residential Services			
Day Services (regular)			
Day Services (special)			
Transportation			
Drop-In Program			
Enhanced Program Support			
Other (Clinical, etc)			

NEW TOTAL PLAN AMOUNT (Currently approved funding total plus proposed increased funding)			
Service Type	Per Diem	Current fiscal Year Cost	Full Year Annualized
Total Residential Funding			
Day Services (regular)			
Day Services (special)			
Transportation			
Drop-In Program			
Enhanced Program Support			
Total Other (Clinical, etc.)			

Program Manager/Centralized Services & Resources			
Request reviewed by Manager / Supervisor?	Yes ☐ No ☐		
Lower cost options available in region?	Yes ☐ No ☐		
Have the lower cost options been exhausted?	Yes ☐ No ☐	**Are you aware of any financial Concerns with the Agency?**	Yes ☐ No ☐
All Cost Share Options have been explored?	Yes ☐ No ☐ N/A ☐	**Are there any Service Concerns with the Agency?**	Yes ☐ No ☐
For Staff Shifted Residential Requests – Is the proposed service an existing vacancy? Yes ☐ No ☐			
Have all regional vacancies been explored first?	Yes ☐ No ☐	**Why vacancies are not an option? Not available** ☐ **Not compatible** ☐ **Vacancy will not meet needs** ☐	

Part B – To be completed by CSW

Presenting Issue (Include a brief and concise summary of the presenting issues and proposed service plan)

Please detail efforts to locate and review appropriateness of lower cost options and any possible cost share

Part C – To be completed by the Program Manager when requesting Enhanced Program Support

Enhanced Program Support Review and Approval Checklist

#	Description of Needs	Yes or No
Not Applicable ☐ – Not Requesting Enhanced Program Support		
An affirmative response to any of numbers 1 through 6 would indicate that the individual is a strong candidate for Enhanced Program Support services		
1	Does the individual present significant risk to self or others in the community (ie: sexual offending, aggression, etc.)?	Yes ☐ No ☐
2	Is the individual involved in the Criminal Justice System and under Probation or Parole conditions?	Yes ☐ No ☐
3	Is the individual currently under an order with the Manitoba Board of Review (Not Criminally Responsible designation)?	Yes ☐ No ☐
4	Does the individual have a history and/or actively engaged in a high risk lifestyle (sex trade, gang activity or affiliation, chronic illicit drug use, etc.)?	Yes ☐ No ☐
5	Does the individual have an un-treated or difficult to manage co-occurring mental health diagnosis?	Yes ☐ No ☐
6	Does the individual have exceptional/complex medical support needs requiring the development and oversight of complex car plans and regular occurring or ongoing specialized services from medical professionals (Complex Feeding Assistance ie: Tube Feeding, Respiratory Care, Immune System Impairment, Complex Seizure Management, etc.)?	Yes ☐ No ☐
Three or more affirmative responses to numbers 7 through 12 would indicate that the individual be considered for Enhanced Program Support services		
7	Is the individual aging out of CFS care and requires significant Case Coordination involvement?	Yes ☐ No ☐
8	Does the individual have chronic housing issues (multiple evictions, hard to house, etc.)?	Yes ☐ No ☐
9	Is the individual being discharged from Hospital, Crisis Stabilization or Correctional Facility?	Yes ☐ No ☐
10	Does the individual have a recent history of victimization, abuse investigations, and protection concerns?	Yes ☐ No ☐
11	Is the individual at risk of self harm, suicide threats/ideation and/or does the individual have a recent history of self harm behaviors and suicide threats/ideation?	Yes ☐ No ☐
12	Does the individual have complex or unique family involvement and/or dynamics that would require significant Case Coordination involvement?	Yes ☐ No ☐
Comments:		

☐ Approved (short Term) ☐ Approved (ongoing) ☐ Not Approved Approved By: