Consent for Release/Receipt of Information

I,_____ of,_____
(print full name of person) *(address)*

hereby consent to

_____
(name of agency/department)

- ☐ Receiving
- ☐ Releasing

the following information:_____
(name specific information wanted)

found in the files of, _____ born on:_____
(name of person) *(DD/MM/YEAR)*

to the_____ , the _____office
(Name of Band/Organization) *(Name of community)*

_____ _____
(Signature) *(Witness)*

Dated this _____day of _____, 20____.

_____
(If other than the client, state relationship to the client)

ANNUAL REVIEW OF CHILDREN/YOUTH RESIDING OUTSIDE THE NWT

Section 1 - REFERRING REGION/AGENCY/AUTHORITY

☐ Beaufort-Delta ☐ Dehcho ☐ Fort Smith

☐ Sahtu ☐ Yellowknife ☐ Hay River

☐ Tłı̨chǫ

CASE MANAGER/CHILD PROTECTION WORKER:	PHONE:	EMAIL:
SUPERVISOR/MANAGER:	PHONE:	EMAIL:

Section 2 – EXTENSION REQUEST

Is the Annual Review of Children/Youth Residing Outside the NWT for a child/youth or a family?

☐ Child/ Youth *For a Child/ Youth request, Section 3 and Appendix A are not required.*

☐ Family *For a Family request, Section 4 is not required.*

Section 3 - FAMILY EXTENSION for TREATMENT SERVICES

How many Dependents / Children are attending the Family Treatment Program? ___

For each dependent/child please fill out the Appendix attached at the end of this form.

Describe the family's level of engagement regarding the Out of Territory Specialized Services:

Section 4 - PERSONAL INFORMATION ON CHILD/YOUTH	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 5 - JUSTIFICATION FOR EXTENSION REQUEST
Describe the reason for the extension and how the child/ youth or family's needs may be supported by the recommended specialized service/ remaining Out of Territory:

Section 6 - MONITORING OF SPECIALIZED SERVICES

Describe the repatriation and discharge plan as applicable:

Describe your face to face and phone contact with the client(s)/ care providers/ courtesy supervision/ supporting agency:

Section 7 - REQUIRED SUPPORTING DOCUMENTATION CHECKLIST

The following documentation is required to support the Annual Review of Children/Youth Residing Outside the NWT:

☐ Court order/CFS agreement that is currently in effect (i.e. VSA, POCA, etc.)

☐ All *relevant* assessments including: medical and psychological assessments from within the past year based on the date of this Extension Request.

☐ Complete "Guardian's Consent for a Child/Youth to Received Services in an Out of Territory Specialized Service" form (note: required annually)

☐ Consent for Release/Exchange of Confidential Information

☐ An updated Concurrent Permanency Plan (this document is not required for family applications when the family is under VSA status), Cultural Support Plan and Social History

Section 8 - APPLICATION VERIFICATION AND APPROVAL

1a. BACKGROUND DOCUMENTATION/ INFORMATION COMPLETE

_____ _____
NWT Case Manager Date

_____ _____
Supervisor/Manager Date

1b. REGIONAL AUTHORIZATION FOR OUT OF TERRITORY CHILD/YOUTH SPECIALIZED SERVICES

_____ _____
Department Head (CEO/COO) Date

2. NORTHWEST TERRITORIES HEALTH AND SOCIAL SERVICES AUTHORITY

NTHSSA reviews documentation, recommends the specialized service

☐ Recommended Application Approval ☐ Recommended Application Denial

_____ _____
Deputy Director, Practice Date

3. DEPARTMENTAL APPROVAL

DHSS reviews documentation, and approves specialized service request extension out of the NWT

☐ Application Approved ☐ Application Denied

_____ _____
Interprovincial and Territorial Services Specialist Date

_____ _____
Deputy Director, DHSS Date

Section 9 - PARENT(S)/LEGAL GUARDIANS(S) CONSENT FOR A CHILD/YOUTH TO RECEIVE SERVICES IN AN OUT OF TERRITORY SPECIALIZED SERVICE

I/We _____, of _____, NT am/ are the
(Parent(s)/Guardian(s)) (City, Town, Hamlet)

Parent(s)/guardian(s) of _____, born on _____,
(Child/Youth's Name) (D/M/Y)

Health Care #: _____.

I/We hereby authorize and consent to the admission of

_____ at _____, in
Child/Youth's Name Title of Specialized Service Program

_____, _____for the purpose of receiving Out of Territory Specialized Services
City/Town Province/Territory

through a _____under the *Child and Family Services Act*.
CFSA Status

I/We have been informed by _____, Child and Family Services Worker about the types of services
Case Manager/Child Protection Worker Name

our child will receive at the above named specialized service program and any risks associated with my child/youth attending the specialized services resource.

I/We understand that the above named specialized service is **not** a locked facility. I/We understand and been informed that our child **could** leave the specialized service program on their own.

I/We have been informed that if our child/youth was to leave from program services without authorization, I/We will be notified by the Case Manager/Child Protection Worker.

I/We further agree to fully cooperate with the Department of Health and Social Services and the specialized service program in the process of either returning my child or participating in discharge planning for my child.

This consent for use of specialized services outside of the Northwest Territories is given with my full understanding and approval as the parent(s)/guardian(s) of the above named child/youth

_____ _____
Signature of Parent/Guardian Signature of Witness

_____ _____
Signature of Parent/Guardian Signature of Witness

I _____ of _____, NT by way of this document declare that I have fully explained the above consent to the parent(s)/guardian(s) and they have indicated to me their understanding of same.

Dated this _____day of _____ 20____

_____ _____
Signature of Case Manager/Child Protection Worker Signature of Witness

Section 10 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES CONSENT FOR RELEASE/ EXCHANGE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION

The personal information on this form is being collected under the authority and administration of the *NWT Child and Family Services Act* (the Act), section 71-74, and can be released by the Director of Child and Family Services in accordance with the Act. If you have any questions contact your Case Manager at the NTHSSA, TCSA and HRHSSA.

Having read and understood this form, I/We _____ (print name of parent(s)/guardian(s)) hereby authorize the release/request the following information to/from the persons/agencies listed below:

Agency/Person	Parent(s)/Guardian(s) Initial(s)	Date	Area of Disclosure
Deputy Director, Department of Health and Social Services			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Deputy Director Practice, Northwest Territories Health and Social Services Authority			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Specialized Service Provider			All information relevant to the referral and ongoing treatment and residential care for OOT Specialized Services.
Region/Authority/Agency			All information relevant to the referral and ongoing case management for OOT Specialized Services.

regarding _____ born on _____.
Child/Youth's Name Child/Youth's DOB (mm/dd/yyyy)

Possible areas of disclosure may include medical, psychiatric, psychological and educational assessments, treatment plan, discharge summary, progress reports, and legal status relating to the above named child/youth.

I understand that no other information will be released to any persons without my written consent, with the following exceptions:

1. In cases of suspected child abuse or neglect, and in cases of current or past sexual abuse in which the child/youth may have present access to minor aged children, staff are obligated to inform the appropriate authorities;
2. If the child/youth states that he/she intends to inflict bodily harm to another person;
3. If the child/youth states that he/she intends to inflict bodily harm to themselves;
4. Upon subpoena to testify in court at the direction of a judge or court order;
5. In the event of a medical emergency involving my child/youth.

I understand that I can withdraw this consent to exchange information at any time, and this form becomes null and void one year from the date signed _____ (print expiry date). In order for this release to be valid, this form must be completed and signed by the guardian and the Case Manager/Child Protection Worker.

Child/Youth's name (print)	Signature	Date
Case Manager/CPW's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date

APPENDIX A: (To be Completed with the Application for Families)

Section 1 - PRIMARY PARENT/GUARDIAN INFORMATION

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 2 - SECONDARY PARENT/GUARDIAN INFORMATION (IF APPLICABLE)

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	

	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 3 - PERSONAL INFORMATION ON CHILD/YOUTH	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 3 continued- PERSONAL INFORMATION ON CHILD/YOUTH (IF APPLICABLE)	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

CHILD/YOUTH APPLICATION FORM: OUT OF TERRITORY SPECIALIZED SERVICES

Section 1 - REFERRING REGION/AGENCY/AUTHORITY

☐ Beaufort-Delta ☐ Dehcho ☐ Fort Smith

☐ Sahtu ☐ Yellowknife ☐ Hay River

☐ Tłı̨chǫ

CASE MANAGER/CHILD PROTECTION WORKER:	PHONE:	EMAIL:
SUPERVISOR/MANAGER:	PHONE:	EMAIL:

Section 2 - PERSONAL INFORMATION ON CHILD/YOUTH

FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 3 - VERIFICATION OF OTHER RESOURCES EXPLORED IN THE NWT

Is a letter determining that the child/youth's needs exceed resources available in NWT (Territorial Treatment Centre, Trailcross Treatment Centre) attached?

☐ Yes ☐ No If No, please explain:

Describe child/youth's level of engagement regarding the potential Out-of-Territory Specialized Services:

Section 4 - PERSONAL MEDICAL/HEALTH INFORMATION ON CHILD/YOUTH

Confirmed/Queried Medical Diagnoses:

Current Prescribed Medication(s) and dosing schedule:

SECTION 5 - PRESENTING BEHAVIOURS OF CONCERN

☐ Addiction- Alcohol/Drug seeking behaviours	☐ Damage to Property	☐ Self-Harm
☐ Aggression	☐ High Risk Behaviours	☐ Sexual Offending
Please explain: _____	**Please explain**: _____	☐ Social Isolation
☐ At risk of harm from others	☐ Impulsivity	☐ Suicidal Ideation
☐ AWOL	☐ Non-compliance with medications	☐ Other: _____
☐ Communication/Language Barriers		

Identifiable Triggers, please explain:

Section 6 - OTHER CONCERNS/NEEDS

☐ Acquired Brain Injury	☐ Speech Language Pathology	☐ Developmental Disability
☐ Audiology	☐ Cognitive Disability	☐ Loss/Separation/Grief
☐ Emotional Abuse	☐ Intellectual Disability	☐ Neglect
☐ Medical Needs	☐ Mental Illness	☐ Sexual Abuse
☐ Physical Needs	☐ Physical Disability	☐ Trauma

Previous Assessments (*please attach a copy of each assessment relevant to this placement referral):*

☐ Child Development Team ☐ Counselling ☐ Educational ☐ FASD Clinic ☐ Occupational Therapy

☐ Physical ☐ Psychiatric ☐ Psychological ☐ Other:

Previous Treatment Placements/Dates *(within the NT or outside of the NT):* _____

Recommended Supports:

☐ Assessment and Stabilization

☐ Clinical Intervention for historical trauma (abuse, neglect, abandonment)

☐ Long Term Specialized Services

☐ Psychiatric, Medication and Symptom Management

☐ Supervision and Safety

☐ Assistance with all Activities of Daily Living

☐ Life Skill Development

☐ Medical Supervision

☐ Short Term Treatment

Section 7 - EDUCATION

NAME OF SCHOOL:	**GRADE LEVEL**:
ATTENDANCE: ☐ Absent ☐ Inconsistent ☐ Regular Details:	**CURRICULUM**: ☐ Academic ☐ Non-Academic ☐ Traditional (land-based) ☐ Other

GRADES:

☐ Excelling ☐ Meeting Grade Level ☐ Approaching Grade Expectations

☐ Not Yet Meeting Grade Expectations

INTERVENTIONS IN PLACE FOR STUDENT SUPPORT:

☐ Tutoring ☐ Counselling ☐ Individualized learning plan ☐ Community programs
☐ Assigned Education Assistant ☐ Peer-mentoring ☐ Accommodations ☐ Other

Individual Education Plan: ☐ Yes ☐ No

Accommodation Plan/Modified Plan: ☐ Yes ☐ No

(Please attach learning and accommodation plan)

Briefly describe accommodations or modified programming:

Concerns identified by school *(please attach any supporting documents demonstrating concerns, psychoeducational assessment, and student's most recent report card):*

Section 8 - CFS LEGAL STATUS AND INVOLVEMENT WITH CHILD/YOUTH

☐ VSA ☐ SSA ☐ POCA ☐ SO ☐ TCO ☐ PCO Status Expiry Date:

Date of initial involvement (prevention/protection):

Age of child/youth on initial involvement:

# of CFS Legal Status: (please list)

# of CFS Foster Placements:

Current Legal Guardians:

Current Caregiver(s)/ Foster Caregiver(s)

Other caregivers formally/currently involved:

Section 9 - COMMUNITY AGENCY SUPPORT(S) FOR CHILD/YOUTH

Which Community Agencies are involved? *(Please attach any assessment summaries or recommendations)*

☐ Counsellor
☐ Physician/ Health Care
☐ RCMP
☐ Child and Youth Worker
☐ Elder(s)
☐ Probation
☐ Rehabilitation Services (Occupational Therapy, Physiotherapy, Speech Language Pathology)
☐ Other (Explain):

Section 10 - PAST/CURRENT CRIMINAL HISTORY

Does the child/youth have a prior criminal record?

☐ No ☐ If yes, what are the conviction(s):

Is the child/youth currently on probation?

☐ No ☐ If yes, what are the conviction(s):

Are there criminal charges pending?

☐ No ☐ If yes, what are the charge(s):

Section 11 - SUPPORTING DOCUMENTATION CHECKLIST

The following documentation is required for a Child/Youth Application Form for Out of Territory Specialized Services:

Authorized Forms:

☐ Consent for Release/Exchange of Personal Information and Personal Health Information
☐ Parent/Legal Guardian's Consent for Child/Youth to Receive Services in an Out of Territory Specialized Resource
☐ Child/Youth Application Form: Out of Territory Specialized Services

Supporting Documentation Required:

☐ Case Plan for Treatment
☐ Copy of Agreement/Order of child/youth's current CFS status
☐ Copy of Birth Certificate
☐ Copy of Clinical Assessments relevant to the referral
☐ Copy of Current Health Care Card
☐ Copy of Probation Order (if applicable)
☐ First Nations Status Card, Métis Citizenship Card, or Nunavut Inuit Enrolment Card (NTI) (if applicable)
☐ List of current medications (if applicable)
☐ Concurrent Permanency Plan
☐ Cultural Support Plan
☐ Social History

Section 12 - APPLICATION RECOMMENDATION AND APPROVAL

1a. BACKGROUND DOCUMENTATION/INFORMATION COMPLETE

_____ _____
NWT Case Manager Date

_____ _____
Supervisor/Manager Date

1b. REGIONAL AUTHORIZATION FOR OUT OF TERRITORY CHILD/YOUTH SPECIALIZED SERVICES

_____ _____
Department Head (CEO/COO) Date

2. NORTHWEST TERRITORIES HEALTH AND SOCIAL SERVICES AUTHORITY

NTHSSA reviews documentation, recommends the specialized service

☐ Recommended Application Approval ☐ Recommended Application Denial

_____ _____
Deputy Director, Practice Date

3. DEPARTMENTAL APPROVAL

DHSS reviews documentation, and approves specialized service out of the NWT

☐ Application Approved ☐ Application Denied

_____ _____
Interprovincial and Territorial Services Specialist Date

_____ _____
Deputy Director, DHSS Date

Section 13 - PARENT(S)/LEGAL GUARDIANS(S) CONSENT FOR A CHILD/YOUTH TO RECEIVE SERVICES IN AN OUT OF TERRITORY SPECIALIZED SERVICE

I/We _____, of _____, NT am/are the Parent(s)/Guardian(s) of
(Parent(s)/Guardian(s)) (City, Town, Hamlet)

_____, born on _____, Health Care # _____
(Child/Youth's Name) (D/M/Y)

I/We hereby authorize and consent to the admission of

_____ at _____, in _____, _____
Child/Youth's Name Title of Specialized Service Program City/Town Province/Territory

for the purpose of receiving Out of Territory Specialized Services through a _____ under the *Child and Family Services Act*.
CFS Status

I/We have been informed by _____, Child and Family Services Worker about the types of services
Case Manager/Child Protection Worker Name
our child will receive at the above named specialized service program and any risks associated with my child/youth attending the specialized services resource.

I/We understand that the above named specialized service is **not** a locked facility. I/We understand and been informed that our child **could** leave the specialized service program on their own.

I/We have been informed that if our child/youth was to leave from program services without authorization, I/We will be notified by the Case Manager/Child Protection Worker.

I/We further agree to fully cooperate with the Department of Health and Social Services and the specialized service program in the process of either returning my child or participating in discharge planning for my child.

This consent for use of specialized services outside of the Northwest Territories is given with my full understanding and approval as the parent(s)/guardian(s) of the above named child/youth.

This consent is in effect from _____20____ to _____ 20___ *(not to exceed one year).*

Dated this _____ day of_____ 20___

_____ _____
Signature of Parent/Guardian Signature of Witness

_____ _____
Signature of Parent/Guardian Signature of Witness

I _____ of _____, NT by way of this document declare that I have fully explained the above consent to the parent(s)/guardian(s) and they have indicated to me their understanding of same.

Dated this _____day of _____ 20____

_____ _____
Signature of Case Manager/Child Protection Worker Signature of Witness

Section 14 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES CONSENT FOR RELEASE/ EXCHANGE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION

The personal information on this form is being collected under the authority and administration of the *NWT Child and Family Services Act* (the Act), section 71-74, and can be released by the Director of Child and Family Services in accordance with the Act. If you have any questions contact your Case Manager at the NTHSSA, TCSA and HRHSSA.

Having read and understood this form, I/We _____ (print name of parent(s)/guardian(s)) hereby authorize the release/request the following information to/from the persons/agencies listed below:

Agency/Person	Parent(s)/Guardian(s) Initial(s)	Date	Area of Disclosure
Deputy Director, Department of Health and Social Services			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Deputy Director Practice, Northwest Territories Health and Social Services Authority			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Specialized Service Provider			All information relevant to the referral and ongoing treatment and residential care for OOT Specialized Services.
Region/Authority/Agency			All information relevant to the referral and ongoing case management for OOT Specialized Services.

regarding _____ born on _____.
Child/Youth's Name Child/Youth's DOB (mm/dd/yyyy)

Possible areas of disclosure may include medical, psychiatric, psychological and educational assessments, treatment plan, discharge summary, progress reports, and legal status relating to the above named child/youth.

I understand that no other information will be released to any persons without my written consent, with the following exceptions:

1. In cases of suspected child abuse or neglect, and in cases of current or past sexual abuse in which the child/youth may have present access to minor aged children, staff are obligated to inform the appropriate authorities;
2. If the child/youth states that he/she intends to inflict bodily harm to another person;
3. If the child/youth states that he/she intends to inflict bodily harm to themselves;
4. Upon subpoena to testify in court at the direction of a judge or court order;
5. In the event of a medical emergency involving my child/youth.

I understand that I can withdraw this consent to exchange information at any time, and this form becomes null and void one year from the date signed _____ (print expiry date). In order for this release to be valid, this form must be completed and signed by the guardian and the Case Manager/Child Protection Worker.

Child/Youth's name (print)	Signature	Date
Case Manager/CPW's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date

EXTENSION REQUEST APPLICATION FORM: OUT OF TERRITORY SPECIALIZED SERVICES

Section 1 - REFERRING REGION/AGENCY/AUTHORITY

☐ Beaufort-Delta ☐ Dehcho ☐ Fort Smith

☐ Sahtu ☐ Yellowknife ☐ Hay River

☐ Tłı̨chǫ

CASE MANAGER/CHILD PROTECTION WORKER:	PHONE:	EMAIL:
SUPERVISOR/MANAGER:	PHONE:	EMAIL:

Section 2 – EXTENSION REQUEST

Is the Extension Request for Out of Territory Specialized Services for a child/youth or a family?

☐ Child/ Youth *For a Child/ Youth request, Section 3 and Appendix A are not required.*

☐ Family *For a Family request, Section 4 is not required.*

Section 3 - FAMILY EXTENSION

How many Dependents / Children are attending the Family Treatment Program? ___

For each dependent/child please fill out the Appendix attached at the end of this form.

Describe the family's level of engagement regarding the potential Out of Territory Specialized Services:

Section 4 - PERSONAL INFORMATION ON CHILD/YOUTH	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 5 - JUSTIFICATION FOR EXTENSION REQUEST
Describe the reason for the extension and how the child/ youth or family's needs may be supported by the recommended specialized service:

Section 6 - MONITORING OF SPECIALIZED SERVICES
Describe the repatriation and discharge plan as applicable:
Describe your face to face and phone contact with the client(s)/ care providers/ courtesy supervision/ supporting agency:

Section 7 - REQUIRED SUPPORTING DOCUMENTATION CHECKLIST

The following documentation is required to support an Extension Request Application Form for Out of Territory Specialized Services:

☐ Court order/CFS agreement that is currently in effect (i.e. VSA, POCA, etc.)

☐ All *relevant* assessments including: medical and psychological assessments from within the past year based on the date of this Extension Request.

☐ Complete "Guardian's Consent for a Child/Youth to Received Services in an Out of Territory Specialized Service" form (note: required annually)

☐ Consent for Release/Exchange of Confidential Information

☐ An updated Concurrent Permanency Plan (this document is not required for family applications when the family is under VSA status), Cultural Support Plan and Social History

Section 8 - APPLICATION VERIFICATION AND APPROVAL

1a. BACKGROUND DOCUMENTATION/ INFORMATION COMPLETE

_____ _____
NWT Case Manager Date

_____ _____
Supervisor/Manager Date

1b. REGIONAL AUTHORIZATION FOR OUT OF TERRITORY CHILD/YOUTH SPECIALIZED SERVICES

_____ _____
Department Head (CEO/COO) Date

2. NORTHWEST TERRITORIES HEALTH AND SOCIAL SERVICES AUTHORITY

NTHSSA reviews documentation, recommends the specialized service

☐ Recommended Application Approval ☐ Recommended Application Denial

_____ _____
Deputy Director, Practice Date

3. DEPARTMENTAL APPROVAL

DHSS reviews documentation, and approves specialized service request extension out of the NWT

☐ Application Approved ☐ Application Denied

_____ _____
Interprovincial and Territorial Services Specialist Date

_____ _____
Deputy Director, DHSS Date

Section 9 - PARENT(S)/LEGAL GUARDIANS(S) CONSENT FOR A CHILD/YOUTH TO RECEIVE SERVICES IN AN OUT OF TERRITORY SPECIALIZED SERVICE

I/We _____, of _____, NT am/ are the
(Parent(s)/Guardian(s)) (City, Town, Hamlet)

Parent(s)/guardian(s) of _____, born on _____,
(Child/Youth's Name) (D/M/Y)

Health Care #: _____.

I/We hereby authorize and consent to the admission of

_____ at _____, in
Child/Youth's Name Title of Specialized Service Program

_____, _____for the purpose of receiving Out of Territory Specialized Services
City/Town Province/Territory

through a _____under the *Child and Family Services Act*.
CFSA Status

I/We have been informed by _____, Child and Family Services Worker about the types of services
Case Manager/Child Protection Worker Name
our child will receive at the above named specialized service program and any risks associated with my child/youth attending the specialized services resource.

I/We understand that the above named specialized service is **not** a locked facility. I/We understand and been informed that our child **could** leave the specialized service program on their own.

I/We have been informed that if our child/youth was to leave from program services without authorization, I/We will be notified by the Case Manager/Child Protection Worker.

I/We further agree to fully cooperate with the Department of Health and Social Services and the specialized service program in the process of either returning my child or participating in discharge planning for my child.

This consent for use of specialized services outside of the Northwest Territories is given with my full understanding and approval as the parent(s)/guardian(s) of the above named child/youth

_____ _____
Signature of Parent/Guardian Signature of Witness

_____ _____
Signature of Parent/Guardian Signature of Witness

I _____ of _____, NT by way of this document declare that I have fully explained the above consent to the parent(s)/guardian(s) and they have indicated to me their understanding of same.

Dated this _____day of _____ 20____

_____ _____
Signature of Case Manager/Child Protection Worker Signature of Witness

Section 10 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES CONSENT FOR RELEASE/ EXCHANGE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION

The personal information on this form is being collected under the authority and administration of the *NWT Child and Family Services Act* (the Act), section 71-74, and can be released by the Director of Child and Family Services in accordance with the Act. If you have any questions contact your Case Manager at the NTHSSA, TCSA and HRHSSA.

Having read and understood this form, I/We _____ (print name of parent(s)/guardian(s)) hereby authorize the release/request the following information to/from the persons/agencies listed below:

Agency/Person	Parent(s)/Guardian(s) Initial(s)	Date	Area of Disclosure
Deputy Director, Department of Health and Social Services			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Deputy Director Practice, Northwest Territories Health and Social Services Authority			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Specialized Service Provider			All information relevant to the referral and ongoing treatment and residential care for OOT Specialized Services.
Region/Authority/Agency			All information relevant to the referral and ongoing case management for OOT Specialized Services.

regarding _____ born on _____.
Child/Youth's Name Child/Youth's DOB (mm/dd/yyyy)

Possible areas of disclosure may include medical, psychiatric, psychological and educational assessments, treatment plan, discharge summary, progress reports, and legal status relating to the above named child/youth.

I understand that no other information will be released to any persons without my written consent, with the following exceptions:

1. In cases of suspected child abuse or neglect, and in cases of current or past sexual abuse in which the child/youth may have present access to minor aged children, staff are obligated to inform the appropriate authorities;
2. If the child/youth states that he/she intends to inflict bodily harm to another person;
3. If the child/youth states that he/she intends to inflict bodily harm to themselves;
4. Upon subpoena to testify in court at the direction of a judge or court order;
5. In the event of a medical emergency involving my child/youth.

I understand that I can withdraw this consent to exchange information at any time, and this form becomes null and void one year from the date signed _____ (print expiry date). In order for this release to be valid, this form must be completed and signed by the guardian and the Case Manager/Child Protection Worker.

Child/Youth's name (print)	Signature	Date
Case Manager/CPW's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date

APPENDIX A: (To be Completed with the Application for Families)

Section 1 - PRIMARY PARENT/GUARDIAN INFORMATION

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 2 - SECONDARY PARENT/GUARDIAN INFORMATION (IF APPLICABLE)

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 3 - PERSONAL INFORMATION ON CHILD/YOUTH	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 3 continued- PERSONAL INFORMATION ON CHILD/YOUTH (IF APPLICABLE)	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

FAMILY TREATMENT PROGRAM APPLICATION FORM: OUT OF TERRITORY SPECIALIZED SERVICES

Section 1 - REFERRING REGION/AGENCY/AUTHORITY

☐ Beaufort-Delta ☐ Dehcho ☐ Fort Smith

☐ Sahtu ☐ Yellowknife ☐ Hay River

☐ Tłı̨chǫ

CASE MANAGER/CHILD PROTECTION WORKER:	PHONE:	EMAIL:
SUPERVISOR/MANAGER:	PHONE:	EMAIL:

Section 2 – PRIMARY PARENT/GUARDIAN INFORMATION

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

PRIMARY PARENT/GUARDIAN MEDICAL/HEALTH INFORMATION

Confirmed/Queried Medical Diagnoses:

Section 2 – PRIMARY PARENT/GUARDIAN MEDICAL/HEALTH INFORMATION

Current Prescribed Medication(s):

Section 3 – SECONDARY PARENT/GUARDIAN INFORMATION (IF APPLICABLE)

FIRST NAME:	LAST NAME:
MATRIX ID #:	Community:
Gender: ☐ Female ☐ Male ☐ X	DOB: MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

SECONDARY PARENT/GUARDIAN MEDICAL/HEALTH INFORMATION

Confirmed/Queried Medical Diagnoses:

Current Prescribed Medication(s):

Section 4 - PERSONAL INFORMATION ON CHILD/YOUTH

How many Dependents / Children will be attending Family Treatment Program? ___

For each dependent/child please fill out the Appendix attached at the end of this form.

Describe each child/youth's level of engagement regarding the potential Out of Territory Specialized Services:

Section 5 - CFS STATUS AND INVOLVEMENT FOR FAMILY

☐ VSA ☐ SSA ☐ POCA ☐ SO ☐ TCO ☐ PCO Status Expiry Date:

INITIAL INVOLVEMENT FOR CFS:

Date of initial involvement (prevention/protection):

# of CFS Status: (please list)

# of CFS Foster Placements:

Guardian(s):

Current Caregiver(s)/Foster Caregiver(s):

Section 6 - COMMUNITY AGENCY SUPPORT(S) FOR FAMILY

Which Community Agencies are involved? *(Please attach any assessment summaries or recommendations)*

- ☐ Counsellor
- ☐ Physician/ Health Care
- ☐ RCMP
- ☐ Child and Youth Worker
- ☐ Elder(s)
- ☐ Probation
- ☐ Rehabilitation Services (Occupational Therapy, Physiotherapy, Speech Language Pathology)
- ☐ Other (Explain):

Section 7 - PAST/CURRENT CRIMINAL HISTORY

Does the child/youth in the family have a prior criminal record?

☐ No ☐ If yes, what are the conviction(s):

Is the child/youth currently on probation?

☐ No ☐ If yes, what are the conviction(s):

Are there criminal charges pending?

☐ No ☐ If yes, what are the charge(s):

Section 8 - SUPPORTING DOCUMENTATION CHECKLIST

The following documentation is required for the Family Treatment Program Application Form for Out of Territory Specialized Services:

Authorized Forms:

☐ DHSS Consent for Release/Exchange of Personal Information and Personal Health Information
☐ Parent/Legal Guardian's Consent for Child/Youth to Receive Services in an Out of Territory Specialized Resource
☐ Family Treatment Program Application Form: Out of Territory Specialized Services

Supporting Documentation Required:

☐ Case Plan for Treatment
☐ Copy of Agreement/Order of child/youth's current CFS status
☐ Copy of Birth Certificate
☐ Copy of Clinical Assessments relevant to the referral
☐ Copy of Current Health Care Card
☐ Copy of Probation Order (if applicable)
☐ First Nations Status Card, Métis Citizenship Card, or Nunavut Inuit Enrolment Card (NTI) (if applicable)
☐ List of current medications (if applicable)
☐ Concurrent Permanency Plan (not applicable for family's with Voluntary Service Agreements)
☐ Cultural Support Plan
☐ Social History

Section 9 - APPLICATION VERIFICATION AND APPROVAL

1a. BACKGROUND DOCUMENTATION/ INFORMATION COMPLETE

_____ _____
NWT Case Manager Date

_____ _____
Supervisor/Manager Date

1b. REGIONAL AUTHORIZATION FOR OUT OF TERRITORY CHILD/YOUTH SPECIALIZED SERVICES

_____ _____
Department Head (CEO/COO) Date

2. NORTHWEST TERRITORIES HEALTH AND SOCIAL SERVICES AUTHORITY

NTHSSA reviews documentation, recommends the specialized service

☐ Recommend Application Approval ☐ Recommend Application Denial

_____ _____
Deputy Director, Practice Date

3. DEPARTMENTAL APPROVAL

DHSS reviews documentation, and approves specialized service out of the NWT

☐ Application Approved ☐ Application Denied

_____ _____
Interprovincial and Territorial Services Specialist Date

_____ _____
Deputy Director, DHSS Date

Section 10 - PARENT(S)/LEGAL GUARDIANS(S) CONSENT FOR A CHILD/YOUTH TO RECEIVE SERVICES IN AN OUT OF TERRITORY SPECIALIZED SERVICE

I/We _____, of _____, NT am/ are the
(Parent(s)/Guardian(s)) (City, Town, Hamlet)

Parent(s)/guardian(s) of _____, born on _____,
(Child/Youth's Name) (D/M/Y)

Health Care #: _____.

I/We hereby authorize and consent to the admission of

_____ at _____, in
Child/Youth's Name Title of Specialized Service Program

_____, _____for the purpose of receiving Out of Territory Specialized Services
City/Town Province/Territory

through a _____under the *Child and Family Services Act*.
CFSA Status

I/We have been informed by _____, Child and Family Services Worker about the types of services
Case Manager/Child Protection Worker Name

our child will receive at the above named specialized service program and any risks associated with my child/youth attending the specialized services resource.

I/We understand that the above named specialized service is **not** a locked facility. I/We understand and been informed that our child **could** leave the specialized service program on their own.

I/We have been informed that if our child/youth was to leave from program services without authorization, I/We will be notified by the Case Manager/Child Protection Worker.

I/We further agree to fully cooperate with the Department of Health and Social Services and the specialized service program in the process of either returning my child or participating in discharge planning for my child.

This consent for use of specialized services outside of the Northwest Territories is given with my full understanding and approval as the parent(s)/guardian(s) of the above named child/youth

_____ _____
Signature of Parent/Guardian Signature of Witness

_____ _____
Signature of Parent/Guardian Signature of Witness

I _____ of _____, NT by way of this document declare that I have fully explained the above consent to the parent(s)/guardian(s) and they have indicated to me their understanding of same.

Dated this _____day of _____ of 20____

_____ _____
Signature of Case Manager/Child Protection Worker Signature of Witness

Section 11 - DEPARTMENT OF HEALTH AND SOCIAL SERVICES CONSENT FOR RELEASE/ EXCHANGE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION

The personal information on this form is being collected under the authority and administration of the *NWT Child and Family Services Act* (the Act), section 71-74, and can be released by the Director of Child and Family Services in accordance with the Act. If you have any questions contact your Case Manager at the NTHSSA, TCSA and HRHSSA.

Having read and understood this form, I/We _____ (print name of parent(s)/legal guardian(s)) hereby authorize the release/request the following information to/from the persons/agencies listed below:

Agency/Person	Parent(s)/Guardian(s) Initial(s)	Date	Area of Disclosure
Deputy Director, Department of Health and Social Services			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Deputy Director Practice, Northwest Territories Health and Social Services Authority			All information relevant to the referral and ongoing monitoring for OOT Specialized Services.
Specialized Service Provider			All information relevant to the referral and ongoing treatment and residential care for OOT Specialized Services.
Region/Authority/Agency			All information relevant to the referral and ongoing case management for OOT Specialized Services.

regarding _____ born on _____.
Child/Youth's Name Child/Youth's DOB (mm/dd/yyyy)

Possible areas of disclosure may include medical, psychiatric, psychological and educational assessments, treatment plan, discharge summary, progress reports, and legal status relating to the above named child/youth.

I understand that no other information will be released to any persons without my written consent, with the following exceptions:

1. In cases of suspected child abuse or neglect, and in cases of current or past sexual abuse in which the child/youth may have present access to minor aged children, staff are obligated to inform the appropriate authorities;
2. If the child/youth states that he/she intends to inflict bodily harm to another person;
3. If the child/youth states that he/she intends to inflict bodily harm to themselves;
4. Upon subpoena to testify in court at the direction of a judge or court order;
5. In the event of a medical emergency involving my child/youth.

I understand that I can withdraw this consent to exchange information at any time, and this form becomes null and void one year from the date signed _____ (print expiry date). In order for this release to be valid, this form must be completed and signed by the guardian and the Case Manager/Child Protection Worker.

Child/Youth's name (print)	Signature	Date
Case Manager/CPW's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date
Parent/Guardian's name (print)	Signature	Date

APPENDIX A:

FAMILY TREATMENT PROGRAM
OUT OF TERRITORTY SPECIALIZED SERVICES APPLICATION
(To be Completed with the Application of Multiple Children)

Section 1 - PERSONAL INFORMATION ON CHILD/YOUTH	
FIRST NAME:	LAST NAME:
MATRIX ID #:	COMMUNITY:
Gender: ☐ Female ☐ Male ☐ X	DOB: _____ MM DD YYYY
Ethnicity: ☐ Dene ☐ Inuit ☐ Métis ☐ Non-Indigenous ☐ Other:	Health Care Card #: Expiry Date:
☐ First Nation Status Card ☐ Nunavut Inuit Enrolment Card (NTI) ☐ Métis Citizenship Card	Card #: Renewal Date:

Section 1 - MEDICAL/HEALTH INFORMATION
Confirmed/Queried Medical Diagnoses:
Current Prescribed Medication(s):

Section 2 - PRESENTING BEHAVIOURS OF CONCERN

☐ Addiction- Alcohol/Drug seeking behaviours	☐ Damage to Property	☐ Self-Harm
☐ Aggression	☐ High Risk Behaviours	☐ Sexual Offending
Please explain:_____	**Please explain**:_____	☐ Social Isolation
☐ At risk of harm from others	☐ Impulsivity	☐ Suicidal Ideation
☐ AWOL	☐ Non-compliance with medications	☐ Other:_____
☐ Communication/Language Barriers		

Identifiable Triggers, please explain:

Section 3 - OTHER CONCERNS/NEEDS

☐ Acquired Brain Injury	☐ Speech Language Pathology	☐ Developmental Disability
☐ Audiology	☐ Cognitive Disability	☐ Loss/Separation/Grief
☐ Emotional Abuse	☐ Intellectual Disability	☐ Neglect
☐ Medical Needs	☐ Mental Illness	☐ Sexual Abuse
☐ Physical Needs	☐ Physical Disability	☐ Trauma

Previous Assessments (*please attach a copy of each assessment relevant to this placement referral):*

☐ Child Development Team	☐ Counselling	☐ Educational	☐ FASD Clinic	☐ Occupational Therapy
☐ Physical	☐ Psychiatric	☐ Psychological	☐ Other:	

Previous Treatment Placements/Dates *(within the NT or outside of the NT):* _____

Section 4 - OTHER CONCERNS/NEEDS

Recommended Supports:

☐Assessment and Stabilization

☐ Clinical Intervention for historical trauma (abuse, neglect, abandonment)

☐ Long Term Specialized Services

☐Psychiatric, Medication and Symptom Management

☐Supervision and Safety

☐ Assistance with all Activities of Daily Living

☐Life Skill Development

☐Medical Supervision

☐Short Term Treatment

Section 5 - EDUCATION

NAME OF SCHOOL:	**GRADE LEVEL**:
ATTENDANCE: ☐ Absent ☐ Inconsistent ☐ Regular Details:	**CURRICULUM**: ☐ Academic ☐ Non-Academic ☐ Traditional (land-based) ☐ Other

GRADES:

☐ Excelling ☐ Meeting Grade Level ☐ Approaching Grade Expectations

☐ Not Yet Meeting Grade Expectations

INTERVENTIONS FOR STUDENT IMPROVEMENT (MADE BY SCHOOL):

☐ Tutoring ☐ Counselling ☐ Individualized learning plan ☐ Community programs
☐ Assigned Education Assistant ☐ Peer-mentoring ☐ Accommodations ☐ Other

Individual Education Plan: ☐ Yes ☐ No

Accommodation Plan/Modified Plan: ☐ Yes ☐ No

(Please attach learning and accommodation plan)

Briefly describe accommodations or modified programming:

Section 5 - EDUCATION

Concerns identified by school *(please attach any supporting documents demonstrating concerns, psychoeducational assessment, and student's most recent report card):*

Section 6 - PAST/CURRENT CRIMINAL HISTORY

Does the child/youth in the family have a prior criminal record?

☐ No ☐ If yes, what are the conviction(s):

Is the child/youth currently on probation?

☐ No ☐ If yes, what are the conviction(s):

Are there criminal charges pending?

☐ No ☐ If yes, what are the charge(s):

Interprovincial Child Protection Alert

Instructions to Sender
Completed forms are to be faxed or emailed to the Interprovincial Desk at NTIPdesk@gov.nt.ca or emailed to CFS_Director@gov.nt.ca. The originating Interprovincial Desk will then forward to the relevant provinces/territories or Canada wide.

Issued By (province or territory) Northwest Territories

Child Welfare Organization Department of Health & Social Services			
Caseworker	**Telephone**	**Fax**	**Email Address**
Address		**Date of Alert** Click here to enter a	**Alert End/** **Expiry Date if less than 9 months**

Subject of Alert

Full Legal Name	**Date of Birth**	**Last Known Address**

Others Involved in Alert (children, legal partners, others in home, etc.)

Name	**Date of Birth** (if known)	**Relationship to Subject**	**Location/Address/Last Known Whereabouts**
N/A			

Reason for Alert/Cause for Concern (check *all* that apply)

☐ Maternity	☐ **Child Sexual Exploitation/Trafficking**	☐ 'Honour-Based' Violence	☐ Illegal Adoption
☐ Child protection investigation not concluded	☐ Left jurisdiction prior to case closure	☐ Left jurisdiction without approval while under child welfare court-ordered supervision	☐ Child in Care taken from jurisdiction without approval
☐ Child in Care missing believed to have left jurisdiction			

Known History or Risk of Violence

Additional Information

Confidential

Physical Description:

Height	Weight	Hair Colour	Eye Colour
Complexion			
Identifying Marks & Other Information:	•		

☐ **Possible Destinations** (where the subject might be going, if known) or ☒ **Canada Wide**

Include other relevant information that may assist in locating the subject, e.g. Aboriginal Band/Community, known family/friend contact information

Action Required (e.g. alert local hospitals, investigation required, contact caseworker, etc.)

Confidential

Distribute copies as follows:
☒ Originating Interprovincial Coordinator
☒ Receiving Interprovincial Coordinator
☒ Receiving Child Welfare Organizations, hospitals, etc.

Denise Bailey
Interprovincial and OOT services
Territorial Social Programs
Department of Health and Social Services
Government of the Northwest Territories
Phone: 867-767-9061, ext. 49167
Fax: 867-873-7706
Email: denise_bailey@gov.nt.ca

Bethan R.Williams
Manager, Children and Family Services
(Deputy Director CFS/Adoptions)
Territorial Social Programs
Department of Health and Social Services
Government of the Northwest Territories
Phone: 867 767-9061, ext. | poste 49165
Fax: 867 873-7706
Email: bethan_williams-simpson@gov.nt.ca

Interprovincial Request for Services

Originating Province/Territory Northwest Territories

Child Welfare Organization	**Caseworker (contact person)**	**Date**
Government of the Northwest Territories and Northwest Territories Heath and Social Services- Yellowknife Region	Denise Bailey-Interprovincial Coordinator	July 22, 2020
Phone Number	**Fax Number**	**Email Address**
867 7679061 EXT 49167 cell 447-1414	867 873 7706	NTIPdesk@gov.nt.ca

Receiving Province/Territory

(Interprovincial Coordinator will complete this information prior to forwarding to the regional designate if you do not know)

Ministry of Children and Family Services	**Address**	**Postal Code**
Phone Number	**Fax Number**	**Email Address**

Type of Request (check *all* that apply)

☐ Child Welfare Record Check	☐ Background History/Information
☐ Home Study (adoption, foster care, place of safety, etc.)	☐ Courtesy Supervision of a Visit
☐ Service of Court Documents	☐ Interview with alleged perpetrator(s) or victim(s) of abuse
☐ Other – describe:	

Child Information

Full Legal Name	**Date of Birth** (if known)	**Location/Address**

Parent/Caregiver

Full Legal Name	**Date of Birth** (if known)	**Relationship to Child or Caregiver**	**Location/Address**

Reason for Request or Details (briefly describe and attach a separate sheet if necessary)

Distribute copies as follows:
☒ Originating Interprovincial Coordinator
☒ Receiving Interprovincial Coordinator
☐ Receiving Child Welfare Organization

Confidential

Children and Family Services
Department of Health and Social Services
Box 1320, Yellowknife NT X1A 2L9

NORTHWEST TERRITORIES CHILD PROTECTION ALERT

Subject of Alert	
Birth Date:	
Issued by	
Date of Alert	
Cause for concern	
Physical Description	
Possible destinations	
Action Required	
Agency Contact	
Expiry Date	

Sender: _____ Date: _____

Interprovincial Coordinator
Children and Family Services
Department of Health and Social Services
Box 1320, Yellowknife NT X1A 2L9
Phone: (867) 873-7046
Fax: (867) 873-7706

Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

FOR OFFICE USE ONLY POUR USAGE INTERNE SEULEMENT	IM-

NWT HEALTH CARE PLAN TEMPORARY ABSENCE FORM

Health Services Administration
Department of Health and Social Services
Bag #9, Inuvik, NT X0E 0T0
Toll-free: 1-800-661-0830 • Phone: (867) 777-7400
Fax: (867) 777-3197 • Email: healthcarecard@gov.nt.ca

Note: You only need to complete this form if you will be out of the NWT for MORE THAN 3 MONTHS

The personal health information on this form is being collected in accordance with the *Health Information Act* (HIA) and will be used to determine continued eligibility for the NWT Health Care Plan. This information is protected by the privacy provisions under the *HIA* and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about the collection or use of this information, contact the Manager, Health Care Eligibility at 1-800-661-0830.

RÉGIME D'ASSURANCE-MALADIE DES TNO FORMULAIRE D'ABSENCE TEMPORAIRE

Administration des services de santé
Ministère de la Santé et des services sociaux
Sac postal 9, Inuvik NT X0E 0T0
Sans frais : 1-800-661-0830 • Téléphone : 867-777-7400
Télécopieur : 867-777-3197 • Courriel : healthcarecard@gov.nt.ca

Note : Vous ne devez remplir ce formulaire que si vous prévoyez être absent des TNO pour PLUS DE 3 MOIS.

Les renseignements médicaux personnels demandés dans ce formulaire sont recueillis en vertu de la *Loi sur les renseignements sur la santé*. Ils serviront à déterminer l'admissibilité au régime d'assurance-maladie des TNO. Ces renseignements sont protégés conformément aux dispositions sur la protection de la vie privée de la *Loi sur les renseignements sur la santé*, et ils ne seront ni utilisés ni divulgués sauf autorisation ou obligation en vertu de cette loi ou de toute autre loi. Si vous avez des questions à cet effet, contactez le gestionnaire des programmes d'admissibilité aux soins de santé en composant le 1-800-661-0830.

A. Registrant Information
A. Renseignements sur le demandeur

Last Name Nom de famille	First Name Prénom	Middle Name Second prénom
Date of Birth (mm/dd/yyyy) Date de naissance (mm/jj/aaaa)	NWT Health Care Card Number Numéro de carte d'assurance-maladie des TNO	

Spouse/Dependent Information: Please provide Name/Date of Birth/Health Care Number of family members **if they will be living with you during your temporary absence.**
Information sur le conjoint et les personnes à charge : Veuillez fournir le nom, la date de naissance et le numéro d'assurance-maladie des membres de votre famille **qui résideront avec vous pendant votre absence temporaire**.

Last Name Nom de famille	Given Name(s) (First and Middle) Prénom(s) (premier et second)	Date of Birth (mm/dd/yyyy) Date de naissance (mm/jj/aaaa)	Health Care Number Numéro d'assurancemaladie

B. Reason for Absence
B. Raison de l'absence

- ☐ Medical / Médicale
- ☐ Snowbird / Touriste hivernant
- ☐ High Performance Athlete / Athlète de haut niveau
- ☐ Work / Travail
- ☐ School / Études
- ☐ Other / Autre

Attach supporting documents listed on back of form.
Veuillez joindre les documents indiqués au dos du formulaire.

Date Leaving NWT (mm/dd/yyyy) Date de départ des TNO (mm/jj/aaaa)	Date You Anticipate Returning to NWT (mm/dd/yyyy)** Date de retour prévue aux TNO (mm/jj/aaaa)**

Permanent NWT Address
Adresse permanente aux TNO

Home Phone Number N° de tél. à la maison	Cell Phone Number N° de tél. cellulaire	Email Address Adresse de courriel

Temporary Out of Territory Address and Phone Number
Adresse temporaire et numéro de téléphone à l'extérieur des TNO

** Please send in copies of your airline boarding passes or gas receipts to show when you have returned to the NWT.
** Veuillez nous envoyer copie de vos cartes d'embarquement de compagnie aérienne ou de vos reçus d'achat d'essence pour nous confirmer à quel moment vous êtes revenu(e) aux TNO.

C. Declaration

I confirm that:

- I make the NWT my primary place of residence;
- The information that I have given in this application and in the documents I have provided is true and accurate; and
- I consent to officials in the Health Services Administration office verifying this information with immigration authorities, government departments, and other persons as appropriate.

C. Déclaration

Je confirme ce qui suit :

- Les TNO sont mon lieu de résidence habituel;
- Les renseignements fournis dans le présent formulaire et les documents qui l'accompagnent sont exacts;
- J'autorise les fonctionnaires du bureau de l'Administration des services de santé à vérifier ces renseignements auprès des services d'immigration, des ministères gouvernementaux et d'autres personnes, suivant les besoins.

☐ **I have included the necessary supporting documentation outlined in section D and understand there will be a delay in processing my form if I have not done so.**
J'ai inclus tous les documents nécessaires mentionnés à la Section D et je comprends que le traitement de ma demande pourrait être ralenti si ce n'était pas le cas.

Signature of / Signature du ☐ Applicant / demandeur ☐ Parent / parent ☐ Legal Guardian / tuteur légal

X PLEASE PRINT FORM TO SIGN / VEUILLEZ IMPRIMER LE FORMULAIRE POUR LE SIGNER

Signature | Date signed / Date de la signature

Name (please print)
Nom (prière d'écrire en caractères d'imprimerie)

If applicable, / Le cas échéant

X PLEASE PRINT FORM TO SIGN / VEUILLEZ IMPRIMER LE FORMULAIRE POUR LE SIGNER

Signature of spouse/partner / Signature du conjoint | Date signed / Date de la signature

NOTE: Persons 19 years of age and older must sign the Temporary Absence Form.
Note : Les personnes de 19 ans et plus doivent signer le formulaire d'absence temporaire.

D. Important Information

Supporting documents must be attached to your Temporary Absence Form.

Please include the following documents relevant to your reason for absence from the NWT:

1. **Medical**
   - Provide a copy of the medical referral or letter from your health care provider that includes the length of time you will be absent from the NWT for medical reasons.
2. **School**
   - Provide a copy of your Conditional Acceptance Letter from the school **with** your course outline **or** a document from the Registrar's Office for each semester confirming that you are going to post-secondary school full-time (as defined by the school).
3. **Work**
   - Provide your employer's name, address and phone/fax number as a contact reference.
4. **High Performance Athletes**
   - Provide documentation showing that you have received a grant from the Northwest Territories High Performance Athlete Program; or
   - Provide a letter from the National Sporting Organization (NSO) or from a certified NSO coach.
5. **Snowbirds**
   - Provide a copy of your income tax form (personal financial information may be blacked-out); **and**
   - A statutory declaration affirming that you are physically present in the NWT for at least 153 days a year and have not established permanent residency elsewhere.
6. **Other**
   - If you plan on being out of the NWT for an extended period (over three consecutive months), contact Health Services Administration to ask if they need documentation to support your Temporary Absence Form.

REMINDER: It is recommended that you get travel insurance if you are going to be outside of the NWT for an extended period for any reason. Your NWT Health Care Card covers you for medically necessary services provided by a doctor or in a hospital **in Canada** but does **not** cover all expenses such as ground or air ambulance.

Medically necessary services received outside of Canada in an emergency or for sudden illness are reimbursed at NWT rates only. You will be responsible for the difference.

D. Renseignements importants

Vous devez joindre les documents pertinents à votre formulaire d'absence temporaire.

Veuillez fournir les documents appuyant la raison de votre absence des TNO.

1. **Médicale**
   - Veuillez fournir une copie de la recommandation médicale ou une lettre de votre fournisseur de soins de santé indiquant la période où vous serez absent des TNO pour des raisons médicales.
2. **Études**
   - Veuillez fournir une copie de votre lettre d'acceptation conditionnelle de l'établissement concerné **accompagnée** d'une description du programme de formation **ou** d'un document du Bureau du registraire, pour chaque session de cours, confirmant que vous fréquentez un établissement postsecondaire à temps plein (tel que défini par l'établissement).
3. **Travail**
   - Veuillez fournir le nom, l'adresse et le numéro de téléphone ou de télécopieur de votre employeur, à titre de référence.
4. **Athlète de haut niveau**
   - Veuillez fournir un document montrant que vous avez reçu une bourse du Programme de bourses pour les athlètes de haut niveau;
   - une lettre de l'organisme national de sport ou de l'entraîneur certifié de l'association sportive nationale en question.
5. **Touriste hivernant**
   - Veuillez fournir une copie de votre formulaire d'impôts (veuillez obscurcir les autres renseignements financiers);
   - une attestation officielle affirmant que vous êtes physiquement présent aux TNO au moins 153 jours par année et que vous n'avez pas établi de résidence permanente ailleurs.
6. **Autre**
   - Si vous prévoyez vous absenter des TNO pour une période prolongée (plus de trois mois consécutifs), veuillez communiquer avec le bureau de l'Administration des services de santé pour vérifier si vous devez fournir des documents à l'appui de votre formulaire d'absence temporaire.

RAPPEL : L'assurance-voyage est recommandée si vous prévoyez demeurer à l'extérieur des TNO pour une période prolongée, peu importe la raison. Votre carte d'assurance-maladie des TNO couvre uniquement les services médicalement nécessaires fournis par un médecin ou dans un hôpital **du Canada**, mais ne couvre **pas** toutes les dépenses, comme le transport en ambulance (sur terre ou dans les airs).

Les soins de santé médicalement nécessaires reçus ailleurs qu'au Canada dans le cadre d'une situation d'urgence ou à la suite d'une maladie soudaine sont remboursés selon les tarifs en vigueur aux TNO. Vous devrez payer la différence.

If you would like this information in another official language, contact us at 1-855-846-9601. / Si vous voulez ces informations dans une autre langue officielle, téléphonez-nous au 1-855-846-9601.