

**REQUEST FOR SUPPORT**  
**COGNITIVE DISABILITY STRATEGY INTAKE COMMITTEE**

c/o Cathy Deneiko (Cognitive Disability Consultant)  
Saskatchewan Association for Community Living  
3031 Louise Street  
Saskatoon, Saskatchewan  
S7J 3L1  
955-3344 ext 17 Fax: 373-3070

*Date form was completed* \_\_\_\_\_

**This form is used to gather information for the intake committee to determine someone's eligibility for the Cognitive Disability Strategy. The areas the committee will be looking at are as follows:**

*Please provide information about the 5 points below in relation to the person this request for support is being made for. If you have supporting documentation such as; Psychology Reports, Individual Program Plans, Medical Reports, Vocational Assessments, Level of Care Assessments, etc., this would be helpful information to include. If you do not include supporting documentation, please indicate any documents that were referred to in the written information provided. If additional space is needed feel free to use the back of this paper.*

- Significant limitations in learning and processing information. Individuals are limited in retaining knowledge, learning skills, making decisions, communicating with others

---

---

- Behaviour challenges which result in limited inter-personal, social and emotional functioning

---

---

- Developmental challenges which limit capacity to adapt to daily living in areas such as self-care, independence at home, in the community at work or leisure

---

---

- Limitations and impairments that are persistent and long-term

---

---

- Have unmet needs

---

---

**\*\*\*\*GENERAL INFORMATION\*\*\*\***

Name of person request is for: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Treaty Status: \_\_\_\_\_

DCRE Client Index Number (if applicable): \_\_\_\_\_

Present Residence: \_\_\_\_\_

Present Employment/ Day Program/ School attending: \_\_\_\_\_

\_\_\_\_\_

**\*\*\*\*REFERRAL SOURCE\*\*\*\***

Please provide the name of the person completing this request

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to individual request is for: \_\_\_\_\_

**\*\*\*\*SERVICE BEING REQUESTED\*\*\*\***

Request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for Request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*\*Please identify someone who may be able to play the role of the team coordinator; include a phone number and relationship to person who request is for* \_\_\_\_\_

\_\_\_\_\_

**\*\*\*\*SUPPORT HISTORY\*\*\*\***

Who are the people involved at the present time. Possible people could be:  
*Department of Community Resources and Employment, Young Offender’s Program,  
 School Division, Alvin Buckwold Child Development Program, Family Doctor,  
 Psychiatrist, Psychologist, Mental Health Services, Advocacy Organization, Day  
 Program support, Employer, Day Care, Early Childhood Intervention Program, Kids  
 First Program, etc. – please use back of page if needing more space*

<i>Agency</i>	<i>Contact person at agency</i>	<i>Contact info. Phone number/address</i>	<i>Involved now Yes or No</i>