Manitoba

# Exceptions Review Based on Extraordinary Support Needs

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|---|---|
| **Date Form Completed** | |
| **Name of Individual** | |
| **Community Service Worker (CSW)** | |
| **Service Provider** | |
| **Person Making Request** | |
| **Relationship (to the individual)** | |
| **Contact Information (Mailing Address and Telephone Number)** | |
| **Support Budget Level** | |
| **Support Budget Level Amount** | |

The individual/Substitute Decision Maker (SDM), family member, support network member listed above is requesting that Community Living disABILITY Services (CLDS) consider this individual for additional support in excess to their level based individual budget due to Extraordinary Support needs. Please outline the additional hours or services requested, the associated costs and how they will address the extraordinary support needs.

Please outline other attempts to provide assistance or identify supports to address the above mentioned needs prior to submitting this request:

**Community Service Worker (CSW) Section** (To be completed by the CSW and reviewed by the Supervisor/Program Manager.) Please provide your case manager opinion on this request (for example: what is the likely outcome if additional resources, supports are not put in place, what unique exceptional circumstances for the individual prompted the request, i.e., vulnerabilities, history or risk of abuse, etc.)

The following supporting documentation has been included (from all sources, family, CSW, etc.):

☐ Funding Approval Form (required when requesting additional funding) ☐ Risk Assessment

☐ Behavior Support Plan ☐ Medical Assessment/Information ☐ Legal Documentation

☐ Person-Centred Plan ☐ SIS Assessment ☐ Other: (please specify)

**RELEASE OF INFORMATION TO THE DEPARTMENT OF FAMILIES**

**(Please print off and sign hard copy)**

Participant Name:_____

I, _____ of _____
(Name) (Full Address)

agree to this Exceptions Review Based on Extraordinary Support Needs application from Community Living disABILITY Services through the Department of Families. I understand that this application and all supporting documents will be reviewed by staff employed with the Department of Families in order to make a determination.

I understand that the information obtained or discussed will be treated in a confidential manner and that this release of information will be for a **one year** period from date provided in this release.

Signed: _____
(Applicant)

*Signed: _____
(Legal Guardian, Substitute Decision Maker)
or Order of Committee)

Date: _____ Witness: _____
(Signature)

***Note:** Legal authorization is required when the applicant is under 18 years of age and/or a Substitute Decision Maker has been appointed or an Order of Committee has been granted.