

Application for the Appointment of a Substitute Decision Maker

Under *The Adults Living with an Intellectual Disability Act*, certain requirements must be met in order for a substitute decision maker to be appointed for an individual. These requirements are addressed by the questions asked in this application form. Please answer all questions in as much detail as possible.

Please refer to the *Guide to Completing the Substitute Decision Maker Application* for further explanation and direction in completing this application.

If you need more space to complete your answers, please attach a separate page and include the section numbers (ex: 1.2, A, i).

Ce formulaire de demande existe également en français. Composez le 204-945-5039 ou le 1 800 757-9857 (sans frais).

PART 1 INFORMATION ABOUT THE PERSON FOR WHOM A SUBSTITUTE DECISION MAKER IS REQUESTED – CALLED “THE INDIVIDUAL” IN THIS APPLICATION

1.1 ABOUT THE INDIVIDUAL

Last name	First name	Middle name
_____	_____	_____
Birth date (mm/dd/yyyy)	Gender	
_____	<input type="checkbox"/> M <input type="checkbox"/> F	
Address (street number, street name, town/city, province, postal code)		

Mailing address, if different from above (street number, street name, town/city, province, postal code)		

Type of residence (family home, community residence, foster home, independent living with support, personal care home, developmental centre, etc.)		Living there since?
_____		_____
Who is the main contact person at the residence?		
Name	Title	Phone number
_____	_____	() _____

List ways in which the individual is involved in the community (day programs/work/school)

1. Name of program/work/school: _____

Main contact person at the program/work/school (name, title, phone number)

Attending since? _____

2. Name of program/work/school: _____

Main contact person at the program/work/school (name, title, phone number)

Attending since? _____

3. Name of program/work/school: _____

Main contact person at the program/work/school (name, title, phone number)

Attending since? _____

1.2 IS THE INDIVIDUAL AN ADULT LIVING WITH AN INTELLECTUAL DISABILITY?

(See under Section C – part 1, subsection 1.2 of guide)

A) AN ADULT LIVING WITH AN INTELLECTUAL DISABILITY

(“Intellectual disability” excludes an intellectual disability due exclusively to a mental or psychiatric disorder defined under *The Mental Health Act*.)

The following are the criteria that define “intellectual disability”. Explain why you believe the individual is:

i) a person with *Significant Intellectual Impairment*

ii) a person with *Impaired Adaptive Behaviour*

iii) a person with a disability *Manifested Prior to Age 18*

B) ASSISTANCE MEETING BASIC NEEDS

Describe what kind of assistance the individual needs to meet his or her basic needs for:

Personal care (ex: help with medical issues, personal hygiene, domestic tasks, etc.)

Property (ex: help with money management)

1.3 SUPPORTING DOCUMENTS

(See under Section C – part 1, subsection 1.3 of guide)

Attach documents to support the information provided in questions 1.2 and 6.1.

Examples of supporting documents include:

- evaluation report(s) from psychologists, psychiatrists, pediatricians, school clinicians (speech pathologists, occupational therapists), etc.
- medical records diagnosing a specific developmental disorder, significant cognitive impairment or intellectual disability
- supported living level of care form
- supported living personal financial plan
- individual plan (IP) or individual education plan (IEP)
- behaviour support plan and/or other related information
- existing social history reports
- other

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1.4 INDIVIDUAL'S SOCIAL WORKER/CASE CO-ORDINATOR (IF KNOWN)

Name _____
Mailing address _____
Phone number () _____ Fax () _____

1.5 INDIVIDUAL'S NEAREST RELATIVE

(See under Section C – part 1, subsection 1.5 of guide)

Name _____	Relationship to individual _____
Mailing address _____	
Phone number () _____	

PART 2 INFORMATION ABOUT THE APPLICANT

Name _____	Relationship to individual _____
Mailing address _____	
Phone number () _____	

PART 3 REASON(S) FOR THE APPLICATION

(See under Section C – part 3 of guide)

3.1 WHAT ARE THE CIRCUMSTANCES THAT GIVE YOU REASON TO BELIEVE THAT A SUBSTITUTE DECISION MAKER IS NEEDED AT THIS TIME?

PART 4 INFORMATION ABOUT THE INDIVIDUAL'S SUPPORT NETWORK

(See under Section C – part 4 of guide)

4.1 PEOPLE WHO PROVIDE ADVICE, SUPPORT AND GUIDANCE TO THE INDIVIDUAL

a) Family members

1. Name _____
Mailing address _____
Phone number () _____ Relationship _____

Nature and frequency of involvement _____

2. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

3. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

4. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

b) Others chosen by the individual (friends, paid service/care providers, advocates, etc.)

1. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

2. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

3. Name _____

Mailing address _____

Phone number () _____ Relationship _____

Nature and frequency of involvement _____

4.2 SERVICE/CARE PROVIDER (IF NOT MENTIONED ABOVE)

1. Name	Relationship	Phone number ()
_____	_____	_____
Mailing address		

2. Name	Relationship	Phone number ()
_____	_____	_____
Mailing address		

PART 5 INFORMATION ABOUT THE PROPOSED SUBSTITUTE DECISION MAKER(S) (SDM)

(See under Section C – part 5 of guide)

5.1 SOLE SUBSTITUTE DECISION MAKER(S) (SDM)

1. Name	Relationship
_____	_____
Mailing address	Phone number ()
_____	_____
_____	SDM for Personal care Property
2. Name	Relationship
_____	_____
Mailing address	Phone number ()
_____	_____
_____	SDM for Personal care Property

5.2 JOINT SUBSTITUTE DECISION MAKER(S) (SDM)

1. Name _____ Mailing address _____ _____	Relationship _____ Phone number () _____ SDM for Personal care <input type="checkbox"/> Property <input type="checkbox"/>
2. Name _____ Mailing address _____ _____	Relationship _____ Phone number () _____ SDM for Personal care <input type="checkbox"/> Property <input type="checkbox"/>
3. Name _____ Mailing address _____ _____	Relationship _____ Phone number () _____ SDM for Personal care <input type="checkbox"/> Property <input type="checkbox"/>

5.3 ALTERNATE SUBSTITUTE DECISION MAKER(S) (ASDM)

1. Name _____ Mailing address _____ _____	Relationship _____ Phone number () _____ ASDM for Personal care <input type="checkbox"/> Property <input type="checkbox"/>
2. Name _____ Mailing address _____ _____	Relationship _____ Phone number () _____ ASDM for Personal care <input type="checkbox"/> Property <input type="checkbox"/>

Notes:

- “Schedule A” must be completed if applying to be a substitute decision maker for property.
- “Schedule B” must be completed by all proposed substitute decision makers.
- A Criminal Record Check, Child Abuse Registry Check, and an Adult Abuse Registry Check is required by all proposed substitute decision makers – see “Schedule C”
- If a substitute decision maker is not identified, The Public Trustee will be appointed.

PART 6 DECISION(S) TO BE MADE

(Applicants should read under Section C – part 6 of guide before completing this section)

6.1 DECISION(S) TO BE MADE

Describe below the decision(s) or issue(s) the individual:

- **is facing now and/or expected to face in the reasonably foreseeable future**
AND
- **is not able to make even with the involvement of his or her support network**

A person is considered unable to make a decision when she/he is not able to understand information relevant to making a decision about personal care or the management of property; or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of one.

What decision(s) or issue(s) is/are there in the area of personal care?

What decision(s) or issue(s) is/are there in the area of property?

PART 7 OTHER INFORMATION REQUIRED

7.1 Considering the decision(s) to be made in Part 6, what should be the length of time of the substitute decision maker appointment? *(See under Section C – part 7, subsection 7.1 of guide)*

7.2 Is there currently a substitute decision maker appointed for the individual? Yes No

Has there been in the past? Yes No

7.3 Does the individual have a committee appointed by the Court of Queen’s Bench or an Order of Committeeship under The Mental Health Act? *(See under Section C – part 7, subsection 7.3 of guide)*
Yes No

7.4 Describe any physical or communication arrangements that will be needed for the individual, the proposed substitute decision maker and/or other parties should they need to participate at a hearing panel. *(See under Section C – part 7, subsection 7.4 of guide)*

7.5 Do you have further information or comments that would be helpful to the commissioner in considering this application for appointment of a substitute decision maker?

SIGNATURE OF APPLICANT

Signature

Date

Have you:

- completed the application in full
- enclosed supporting documents noted on page 3
- completed “Schedule A” – real and personal property (if applying for property)
- completed “Schedule B” – consent form signed by the proposed substitute decision maker(s)
- enclosed the Criminal Record Check(s), Child Abuse Registry Check(s), and Adult Abuse Registry Check for all proposed substitute decision makers – See “Schedule C”

Note: Incomplete application packages will take longer to process.

Send completed applications and documents to:

**Office of the Commissioner for Adults Living
with an Intellectual Disability (CALIDO)**

315-258 Portage Avenue
Winnipeg, Manitoba R3C 0B6
Telephone: 204-945-5039
Toll Free: 1-800-757-9857
Fax: 204-948-3713

FOR COMMUNITY SERVICE WORKER/SOCIAL WORKER USE ONLY

For CALIDO information gathering purposes, if you directly assisted the applicant in completing this application, please complete the following:

1) Do you believe a substitute decision maker is warranted for this individual?

Yes No

Why?

2) Do you believe the proposed substitute decision maker(s) is suitable, capable and able to perform the duties of a substitute decision maker?

Yes No

Why?

3) Do you have further information or comments that would be helpful to the commissioner in this application for appointment of a substitute decision maker?

SIGNATURE OF CSW/SOCIAL WORKER

Signature of CSW/Social Worker

Date