Focal Point Case Management Form

Today's Date (MM/DD/YYYY)

1.0 Origin of Request

Was the request received from the Non-Insured Health Benefits (NIHB) program?

- ○ Yes
- ○ No

If yes, please enter the NIHB PA/PD/SA/TA number (if applicable):

If no, request received from (check all that apply) :

- ☐ Parent/Guardian/Family Member/Child
- ☐ Community-Based Worker
- ☐ Health Professional
- ☐ Regional Health Authority
- ☐ Other
- ☐ Regional Service Coordination Organisation
- ☐ School
- ☐ Child and Family Services Agency
- ☐ NIHB Navigator

2.0 Primary Client Demographic Information

Assigned Unique Case # (e.g., HC-AB-0001)

Child's Given Name

Child's Family Name

Child's Date of Birth (MM/DD/YYYY)

Child's Sex

- ○ Male
- ○ Female

Community of Residence – ALBERTA

Community of Residence – BRITISH COLUMBIA

Community of Residence – MANITOBA

Community of Residence – ATLANTIC

Community of Residence – ONTARIO

Community of Residence – QUEBEC

Community of Residence – SASKATCHEWAN

Community of Residence – YUKON

Address where child currently resides (full address with postal code)

3.0 Client Information

3.1 Residence

Does the child ordinarily reside on reserve?

- ○ Yes
- ○ No

If no, was the reason for leaving to access services (health, social, educational)?

- ○ Yes
- ○ No

Is the child in foster care?

- ○ Yes
- ○ No

If the child lives off-reserve or not in one of the above communities, please provide details including location of current residence :

3.2 Age

Is the request for a child (as defined by the province/territory of residence)?

- ○ Yes
- ○ No

If the request is not for a child (as defined by the province/territory of residence), please provide details:

3.3 Status

Is the child a Registered Indian as per INAC's Indian Registration System?

- ○ Yes
- ○ No

If yes, child's Indian Registration Number

If no, is Mother a Registered Indian as per INAC's Indian Registration System?

- ○ No
- ○ Yes, Registration #

Mother's Given Name

Mother's Family Name

If no, is Father a Registered Indian as per INAC's Indian Registration System?

- ○ No
- ○ Yes, Registration #

Father's Given Name

Father's Family Name

If the child is non-status, please provide details :

3.4 Disability

Does the child have a disability or interim critical condition (less than one year) affecting his/her activities of daily living, requiring health or social supports? (check all that apply)

- ☐ Disability
- ☐ Disability without formal diagnosis
- ☐ Interim Critical Condition
- ☐ Other

If the child does not have a disability or interim critical condition, please provide details

Has an assessment been completed by a health, educational or social professional?

- ○ Yes
- ○ No

If no, has an assessment been requested?

- ○ Yes
- ○ No

What challenges are impacting the child's daily activities? (check all that apply)

- [ ] Vision
- [ ] Hearing
- [ ] Speech
- [ ] Mobility (e.g., walking, bending, lifting, climbing stairs, reaching)
- [ ] Personal care and hygiene (e.g., eating, bathing, dressing, using the toilet)
- [ ] Cognitive activities (e.g., learning, remembering, concentrating)
- [ ] Mental health (e.g., mood, emotions, anxiety, depression)
- [ ] Environmental sensitivities (e.g., lighting, noise)
- [ ] Allergies
- [ ] Metabolic
- [ ] Cardiac/respiratory
- [ ] Other

If diagnosis is currently available, specify here (check all that apply):

- [ ] Allergies
- [ ] Anemia
- [ ] Anxiety disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)
- [ ] Autism spectrum disorder
- [ ] Blindness or serious vision problems
- [ ] Cancer
- [ ] Chronic ear infections
- [ ] Developmental delay/disorder
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fetal Alcohol Spectrum Disorder (FASD)
- [ ] Hearing impairment
- [ ] Heart condition
- [ ] Hepatitis
- [ ] Infection
- [ ] Injury
- [ ] Kidney problem
- [ ] Learning disorder
- [ ] Mood disorder (e.g., depression)
- [ ] Post-traumatic stress
- [ ] Speech/language difficulties
- [ ] Stomach/gastro-intestinal difficulties
- [ ] Suicide risk
- [ ] Thyroid problems
- [ ] Trauma
- [ ] Tuberculosis
- [ ] Diagnosis not currently available
- [ ] Other

4.0 Request History

This request has been previously considered within the following existing jurisdictions: (check all that apply)

- [ ] HC
- [ ] INAC
- [ ] Province/Territory

Under which program(s)? (check all that apply)

- [ ] Non-Insured Health Benefits (NIHB, Health Canada)
- [ ] First Nations and Inuit Home and Community Care (Health Canada)
- [ ] Health Child Development (Health Canada)
- [ ] Primary Care (Health Canada)
- [ ] Mental Wellness (Health Canada)
- [ ] Capital/Infrastructure (Health Canada)
- [ ] Child and Family Services (INAC)
- [ ] High Cost Special Education Program (INAC)
- [ ] Assisted Living Program (INAC)
- [ ] Income Assistance (INAC)
- [ ] Capital/Infrastructure (INAC)
- [ ] Other

Were services available?

- ○ Yes
- ○ Yes, but insufficient
- ○ No

If services not sufficiently covered, explain (check all that apply):

- [ ] Lack of Funds
- [ ] Authority Gaps
- [ ] Payment dispute exists
- [ ] There is unnecessary delay in receiving the service from the provider
- [ ] Product/service excluded by NIHB
- [ ] Other

If lack of funds, please explain:

If authority gap exists, please explain:

If payment dispute, dispute exists between:

If delay, provide details:

If excluded by NIHB, provide details:

5.0 Service Coordination

Please click on all service coordination functions that are involved (check all that apply):

- [ ] Provincial/Territorial Program Service Coordination
- [ ] Federal Program Service Coordination
- [ ] Regional Service Coordination Organisation
- [ ] Health Canada Regional Focal Point
- [ ] INAC Regional Focal Point
- [ ] None
- [ ] Another Service Coordination Organisation (e.g., First Nations Organisation)

Have services/products previously been received from other programs?

- ○ Yes
- ○ No

If yes, which services/products were received (check all that apply):

- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech language therapy
- ☐ Respite care
- ☐ Nursing care
- ☐ Activities of daily living assistance
- ☐ Health teaching (family/child)
- ☐ Mental health consultation
- ☐ Cultural/spiritual care
- ☐ Transportation
- ☐ Nutrition counselling/support
- ☐ Educational/classroom assistance
- ☐ Day programs
- ☐ Capital/renovation assistance
- ☐ Advanced educational assessment
- ☐ Advanced medical assessment
- ☐ Home management assistance
- ☐ Medical supplies and equipment
- ☐ Pharmaceuticals
- ☐ Nutritional supplements
- ☐ Behavioural intervention
- ☐ Neuro-psychological assessment
- ☐ Other

Please specify from which programs these services/products were received (check all that apply)

- ☐ Non-Insured Health Benefits (NIHB, Health Canada)
- ☐ First Nations and Inuit Home and Community Care (Health Canada)
- ☐ Healthy Child Development (Health Canada)
- ☐ Primary Care (Health Canada)
- ☐ Mental Wellness (Health Canada)
- ☐ Capital/Infrastructure (Health Canada)
- ☐ Child and Family Services (INAC)
- ☐ High Cost Special Education (INAC)
- ☐ Assisted Living (INAC)
- ☐ Income Assistance (INAC)
- ☐ Capital/Infrastructure (INAC)
- ☐ Other

5.1 Current Request for Services

Please provide a brief description of the current request(s):

Request Initiation Date (MM/DD/YYYY):

Service professional(s) making recommendation (check all that apply):

- ☐ Audiologist
- ☐ Chiropractor
- ☐ Clinical Nurse Specialist
- ☐ Dentist
- ☐ Dietician/Nutritionist
- ☐ Early Childhood Development Specialist
- ☐ Environmental Health Officer
- ☐ Mental Health Professional
- ☐ Midwife
- ☐ Naturopath
- ☐ Community Health Nurse
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Orthotist
- ☐ Pharmacist
- ☐ Physician
- ☐ Physiologist
- ☐ Physiotherapist
- ☐ Prosthetist
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Social Worker
- ☐ Speech Therapist
- ☐ Surgeon
- ☐ Teacher/educational professional
- ☐ Traditional Healer
- ☐ Other

5.1.1 Product/Service Information

Enter information for all services/products being recommended

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Product or Service 1

Description of Product or Service :

Frequency and Duration of Service (if applicable):

Total Estimated Cost of Product/Service for this Fiscal Year:

Will this product/service be used by more than one child (e.g., a van used to transport multiple children)?

- Yes
- No

If necessary, please elaborate. Note: A completed Case Management Form is required for each eligible child who will be using the product/service.

Does this product/service meet provincial/territorial normative standard?

- Yes
- No

If no, explain why the service/product is still being considered despite not meeting provincial/territorial normative standard:

Was the request for this product/service approved for funding?

- Yes, approved
- No, not approved

Rationale:

If approved, date when payment/funding was approved (MM/DD/YYYY):

If approved, date when product/service was received (MM/DD/YYYY):

If not approved, date client was informed (MM/DD/YYYY):

Product or Service 2

Description of Product or Service :

Frequency and Duration of Service (if applicable):

Total Estimated Cost of Product/Service for this Fiscal Year:

Will this product/service be used by more than one child (e.g., a van used to transport multiple children)?

- Yes
- No

If necessary, please elaborate. Note: A completed Case Management Form is required for each eligible child who will be using the product/service.

Does this product/service meet provincial/territorial normative standard?

- Yes
- No

If no, explain why the service/product is still being considered despite not meeting provincial/territorial normative standard:

Was the request for this product/service approved for funding?

- Yes, approved
- No, not approved

Rationale:

If approved, date when payment/funding was approved (MM/DD/YYYY):

If approved, date when product/service was received (MM/DD/YYYY):

If not approved, date client was informed (MM/DD/YYYY):

Product or Service 3

Description of Product or Service : :

Frequency and Duration of Service (if applicable):

Total Estimated Cost of Product/Service for this Fiscal Year:

Will this product/service be used by more than one child (e.g., a van used to transport multiple children)?

- Yes
- No

If necessary, please elaborate. Note: A completed Case Management Form is required for each eligible child who will be using the product/service.

Does this product/service meet provincial/territorial normative standard?

- Yes
- No

If no, explain why the service/product is still being considered despite not meeting provincial/territorial normative standard:

Was the request for this product/service approved for funding?

- Yes, approved
- No, not approved

Rationale:

If approved, date when payment/funding was approved (MM/DD/YYYY):

If approved, date when product/service was received (MM/DD/YYYY):

If not approved, date client was informed (MM/DD/YYYY):

Product or Service 4

Description of Product or Service :

Frequency and Duration of Service (if applicable):

Total Estimated Cost of Product/Service for this Fiscal Year:

Will this product/service be used by more than one child (e.g., a van used to transport multiple children)?

- Yes
- No

If necessary, please elaborate. Note: A completed Case Management Form is required for each eligible child who will be using the product/service.

Does this product/service meet provincial/territorial normative standard?

- ○ Yes
- ○ No

If no, explain why the service/product is still being considered despite not meeting provincial/territorial normative standard:

Was the request for this product/service approved for funding?

- ○ Yes, approved
- ○ No, not approved

Rationale:

If approved, date when payment/funding was approved (MM/DD/YYYY):

If approved, date when product/service was received (MM/DD/YYYY):

If not approved, date client was informed (MM/DD/YYYY):

Product or Service 5

Description of Product or Service :

Frequency and Duration of Service (if applicable):

Total Estimated Cost of Product/Service for this Fiscal Year:

Will this product/service be used by more than one child (e.g., a van used to transport multiple children)?

- ○ Yes
- ○ No

If necessary, please elaborate. Note: A completed Case Management Form is required for each eligible child who will be using the product/service.

Does this product/service meet provincial/territorial normative standard?

- ○ Yes
- ○ No

If no, explain why the service/product is still being considered despite not meeting provincial/territorial normative standard:

Was the request for this product/service approved for funding?

- ○ Yes, approved
- ○ No, not approved

Rationale:

If approved, date when payment/funding was approved (MM/DD/YYYY):

If approved, date when product/service was received (MM/DD/YYYY):

If approved, date client was informed (MM/DD/YYYY):

6.0 Payment

Payable To :

- ○ Client
- ○ Direct Procurement to Service Provider/Product Distributor
- ○ Direct Procurement to Province/Territory
- ○ Service Coordination Organisation
- ○ Community/Band/Tribal Council
- ○ Other

Was the payment made through O & M or Gs & Cs?

- ○ O & M
- ○ Gs & Cs
- ○ A combination of O & M and Gs & Cs, please explain:

Total Final Cost:

Invoice number, if applicable

Prescription/referral in file?

- ○ Yes
- ○ No

7.0 Notes: Provide any other details relevant to the request