Section One

Protocol for Transitioning Students with Exceptional Needs from School to Community
THE TRANSITION PROTOCOL –
Interactive Roles and Timelines

The transition protocol identifies who is responsible for developing and implementing transition plans for students with exceptional learning needs when they require government supports to enter the community. It outlines the tasks and their timelines.

Partners in transition planning include:
- the student and his/her support network (which may include: parents' and/or legal guardians, siblings, friends, advocates, foster parents or group home staff)
- teachers and school/school division staff/institutional school staff
- community workers from Manitoba Family Services and Housing programs including:
  - Children’s Special Services (CSS)
  - Employment and Income Assistance (EIA)
  - Vocational Rehabilitation (VR) program
  - Supported Living program (SLP)
- or designated agencies including CNIB, Society for Manitobans with Disabilities (SMD), Canadian Paraplegic Association Manitoba Inc. (CPA)
- community workers from regional health authority (RHA) programs in Manitoba including:
  - Community Mental Health (MH) services
  - Home Care program
- community workers from applicable child and family services (CFS) agencies

Transition planning should begin in the school year in which the student enters high school. The process concludes in June of the calendar year in which the student turns 21 or when he/she graduates. During this time, professionals, the student, his/her support network and others work together to provide the student with a co-ordinated transition from school to life in the community.

The transition planning protocol is summarized in Figure 1. The shaded rows outline key responsibilities of transition partners. The columns identify timelines for specific tasks.

See Appendix A for an interactive roles and timeline checklist for case managers.

---

1 In some cases only one parent or legal guardian may be involved in a child’s educational and transition planning. The term “parent” in this document can apply to any of these. The rights and responsibilities of parents may also apply to students once they have reached the age of majority. For information on The Vulnerable Persons Living with a Mental Disability Act, see Appendix H.
### INITIATING THE PROCESS

#### High School Entry
(Age 14 to 16)

<table>
<thead>
<tr>
<th>Age 16 to 17</th>
<th>AGE 17 to 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students and/or parents/guardians with support networks, substitute decision maker (see Appendix H), teachers,</td>
<td></td>
</tr>
<tr>
<td>• become aware of options &amp; planning process</td>
<td></td>
</tr>
<tr>
<td>• think about potential community experiences, graduation date, adult options</td>
<td></td>
</tr>
<tr>
<td>• provide information on strengths/ interests/ dreams</td>
<td></td>
</tr>
<tr>
<td>• explore residential support services of personal preference or plan to reside in family home</td>
<td></td>
</tr>
<tr>
<td>• understand the implications of leaving school before completing graduation requirements, or availability of adult supports</td>
<td></td>
</tr>
<tr>
<td>• at age 18 a person with disability may contact Employment &amp; Income Assistance for assessment of eligibility</td>
<td></td>
</tr>
<tr>
<td>• apply for appropriate ID</td>
<td></td>
</tr>
<tr>
<td>• age 18 may involve move to adult residential facility with support from adult programs (ex: SLP, MH)</td>
<td></td>
</tr>
</tbody>
</table>

#### School

| • appoint case manager for transition planning  |
| • co-ordinate initial planning meeting with those closest to student (IEP team)  |
| • begin appropriate work/community experiences  |
| • explore potential grad date and senior years programming direction with student, family and IEP team  |
| • inform families about adult support options & transition planning process  |
| • contact adult program (SLP, MH, VR) where no children’s worker involved or co-ordinate contact with children’s worker  |
| • co-ordinate annual transition planning meeting  |
| • research eligibility criteria for adult programs  |
| • initiate referrals to adult programs (SLP, VR, MH) in consultation with parents  |
| • include adult worker in IEP/ITP meetings  |
| • assist with gathering information regarding supports required at home & in community  |
| • at age 18 a person with disability may contact Employment & Income Assistance for assessment of eligibility  |
| • apply for appropriate ID  |
| • age 18 may involve move to adult residential facility with support from adult programs (ex: SLP, MH)  |

#### Services for Children

**Child and Family Service Agencies**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the parents  |
| • attend school transitional planning meetings  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

**Children’s Special Services,**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the parents  |
| • attend school transitional planning meetings  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

**Children’s Mental Health**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

---

* May include ongoing career development, volunteer experiences, exploration of day programming options, exposure to recreational opportunities, transportation training, skills for living in the community with independence etc.

### Services for Children

**Child and Family Service Agencies**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the parents  |
| • attend school transitional planning meetings  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

**Children’s Special Services,**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the parents  |
| • attend school transitional planning meetings  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

**Children’s Mental Health**

| • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements  |
| • complete referrals for appropriate adult services in collaboration with the family  |
| • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility  |
| • participate in school transitional planning meetings to ensure continuity of planning for services and supports  |

---

*Note: For children in care of child and family services agencies, CFS/legal guardian should be involved in the process whenever a parent would be involved

---

**In consultation with adult worker**

| • continue to plan and make referrals for required supports  |

---

© continue to plan and make referrals to appropriate adult resources

---

In consultation with adult worker

| • continue to plan and make referrals for required supports  |

---

In consultation with adult worker

| • continue to plan and make referrals for required supports  |
### years where overlap may occur

<table>
<thead>
<tr>
<th>One year Before Graduation</th>
<th>Graduation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>siblings, relatives, friends, advocates, foster parents or group home staff</td>
<td></td>
</tr>
<tr>
<td>• plan for post-secondary education/training, work/community placement, or vocational/day service</td>
<td>• make informed decisions about</td>
</tr>
<tr>
<td>• choose supports that match individual preferences/needs or advocate for new/enhanced services</td>
<td>- employment</td>
</tr>
<tr>
<td></td>
<td>- move to post-secondary education/training, work/community opportunities</td>
</tr>
<tr>
<td></td>
<td>- accessing a variety of supports/services from community based service providers.</td>
</tr>
<tr>
<td></td>
<td>• co-ordinate annual transition planning meetings</td>
</tr>
<tr>
<td></td>
<td>• increase work/community experiences</td>
</tr>
<tr>
<td></td>
<td>• ensure curriculum supports a planned move to post secondary education/training</td>
</tr>
<tr>
<td></td>
<td>• Ensure completion of SLP day services: information gathering and referrals</td>
</tr>
<tr>
<td></td>
<td>• include assigned adult community worker in planning meetings</td>
</tr>
<tr>
<td></td>
<td>• identify resources required: work/community</td>
</tr>
<tr>
<td></td>
<td>• co-ordinate annual transition planning meeting</td>
</tr>
<tr>
<td></td>
<td>• include assigned VR community worker in planning meetings and provide with current information</td>
</tr>
<tr>
<td></td>
<td>• ensure graduation/completion requirements have been met</td>
</tr>
<tr>
<td></td>
<td>• initiate long-term work/community experience</td>
</tr>
<tr>
<td></td>
<td>• co-ordinate continuity of supports with adult community worker or with work/community representative</td>
</tr>
<tr>
<td></td>
<td>• a child and family services agency may continue involvement beyond age 18 for children who are permanent wards under the guardianship of the CFS agency, depending on individual circumstances</td>
</tr>
</tbody>
</table>

continued on next page
### INITIATING THE PROCESS

#### High School Entry
**(Age 14 to 16)**

- Provide transition team with general information re referral process, eligibility criteria, & adult service options

#### Home Care Program
- Receive referral and conduct assessment to determine eligibility
- Provide information on adult resources
- Case co-ordinator collaborates in developing care plan
- Case co-ordinator arranges services specified in care plan
- Participate in the facilitation of alternate residential placement in community

#### Supported Living Program (SLP)
- Acknowledge receipt of referral, check eligibility & assign community worker
- Community worker participates in planning meetings with transition team (at least one before assuming case responsibility)
- Provide information on adult supports/service providers
- Request for funding for residential/support services if required at age 18
- Complete referrals to residential service provider of choice as required
- Provide information for establishment of community supports for adult life, where none currently exist

#### Day Services
- Check eligibility & assign community worker
- Provide information on adult programs and resources in community

#### Regional Health Authorities (RHA)
- Mental Health (MH) Services and Supports
  - Check eligibility and assign community worker
  - Assigned worker participates in planning meetings (at least one before assuming case responsibility)
  - Provide information on adult resources
  - Complete referrals to adult resources
  - Request for funding for residential and/or support services if required at age 18

#### Home Care Program
- Assess and facilitate request for funding for residential/support services if appropriate at age 18

---

**Figure 1 - Interactive Roles and Time Lines In Transition Planning (continued)**

<p>| Services for Adults (Employment and Income Assistance, Supported Living Program, vocational rehabilitation services,) |
|---|---|
| <strong>Age 16 to 17</strong> | <strong>AGE 17 to 18</strong> |
| <strong>High School Entry</strong> (Age 14 to 16) | <strong>High School Entry</strong> (Age 14 to 16) |
|  |  |
|  |  |</p>
<table>
<thead>
<tr>
<th>One year Before Graduation</th>
<th>Graduation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment and Income Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>[• apply in person at age 18 and beyond]</td>
<td></td>
</tr>
</tbody>
</table>

| **Vocational Rehabilitation Program FSH, RHA, designated agency (SMD, CNIB, CPA)**  |                  |
| [• acknowledge receipt of referral, check eligibility & assign community worker] |                  |
| [• community worker participates in meetings with transition team] |                  |
| [• provide information on adult supports/ service providers] |                  |
| [• develop individual vocational plan] |                  |
| [• identify and initiate referral to service provider of choice and request funding for services, including technical assessments, upon student leaving school] |                  |

| **Supported Living Program (SLP) – Day Services**  |                  |
| [• ensure completion of previous steps in the referral process] |                  |
| [• community worker participates in meetings] |                  |
| [• request funding for day service resources two years before graduation date] |                  |
| [• referrals to day service resources and adult clinical services] |                  |
### Interactive Roles and Responsibilities in Transition Planning

#### Manitoba Transition Support System

Transition planning for students who will require government supports when they move from school to life in the community is necessary to ensure co-ordinated service delivery. The transition planning process demands significant collaboration between students, their family/support networks, school divisions, educators and government and community service providers who are responsible for implementing the transition protocol. To accomplish a successful transition, it is important that all those involved with the students work together and fulfill their individual roles and responsibilities.

Figure 2 identifies key supports that may be involved with students in the transition process.

#### Students

Students are the central member of the transition planning team. Their role is critical in goal setting and decision making. Students and their support networks should be active participants in transition planning. Support networks may include parents/legal guardians, siblings, relatives, friends, teachers, advocates, foster parents or group home staff.

Students, with help from their support networks, may participate in transition planning by:
- attending IEP/ITP meetings
- sharing information on his/her interests, skills and hopes for the future with the team
- becoming aware of options and the planning process
- participating in assessment designed to identify current skills and needs
- expressing his/her opinions in the decision making process
- thinking about potential community experiences, graduation date, adult options
- choosing preferences for residential support services or planning to reside in their families home
- understanding the implications of leaving school at age 16 or 17, or graduation before adult supports are available
- at age 18, contacting Employment and Income Assistance for assessment of program eligibility

For legislation affecting transition teams, see Appendix H.
• at age 18, considering a move to an adult residential facility with support from adult programs (ex: Supported Living Program)
• planning for post secondary education/training, work/community placement, or vocational/day service
• choosing supports that match individual preferences/needs
• working hard to complete school requirements

Parents, Legal Guardians, Foster Parents, Caregivers and Support Networks

Parents, legal guardians, foster parents, caregivers and others legally authorized to make decisions are also key members of the transition team. They can ensure that transition planning reflects the interests and values of the student.

The school principal must ensure that parents and students have the opportunity to have a person of their choosing in the process and attend planning meeting, etc.

The suggested roles of these team members include:
• attending IEP/ITP meetings
• sharing their knowledge students’ interests, strengths and needs with the team

• supporting the students in the transition process
• participating in the decision making process
• encouraging and helping students participate in transition planning
• finding information on available services and resources, currently or after graduation
• supporting implementation of the plan
• sharing information about students’ progress
• becoming familiar with The Vulnerable Persons Act (see Appendix H)

Interactive Roles and Responsibilities of Educators

Appropriate Educational Programming in Manitoba: Standards for Student Services (2006) reinforces the transition planning protocol for students who will need adult supports. Teachers’ roles are also outlined in the Pupil File Guidelines (2004). They are available at:
www.edu.gov.mb.ca/k12/specedu/aep
www.edu.gov.mb.ca/k12/docs/policy/mbpupil/index.html

Student Services Administrator
Consistent within Appropriate Educational Programming in Manitoba, the student services administrator or designate within a school division assumes a leading role in transition planning and is responsible for:
• initiating contact early in the school year (at the latest by November 30) with designated personnel from Manitoba Family Services and Housing, regional health authority programs and services, child and family services agencies and others to discuss planning for identified students within the division
• providing consultation and professional learning opportunities to equip the case manager and the school staff for transition planning for students with exceptional learning needs

School Principals
Principals are responsible for students’ Individual Education Plans and transition planning which includes:
• initiating planning for students entering high school who may require adult supports and services when they leave school
• identifying planning case managers within the school and ensuring planning involves teachers and other school staff
• ensuring that transition planning is co-ordinated with students’ educational programming
• involving the registered nurse in transition for Unified Referral and Intake System (URIS) Group A students
• ensuring the involvement of child and family services agencies, Manitoba Family Services and Housing and/or designated agencies (CNIB, Society for Manitobans with Disabilities and Canadian Paraplegic Association Inc.) and/or regional health authority programs and services
• ensuring planning is updated annually, or sooner if required
• ensuring parents are meaningfully involved in decision making
• ensuring parents have the information they need to make informed decisions
• ensuring students’ parents and students have the opportunity to have a person of their choosing at individual planning meetings
• establishing, maintaining and retaining a pupil file for each student in a school
• transferring the pupil file and pupil support file of students transferred to another school, within one week of the new school requesting it

Determining when a student’s right to attend school ends:
Students have the right to attend school until they graduate or until June of the calendar year in which they turn 21. To determine when a student’s right to attend school ends, add 21 to their year of birth. For example:
• Sharad’s birthday is Feb 15, 1990. He is eligible to attend school until June, 2011.
• Courtney’s birthday is December 10, 1990. She is eligible to attend school until June, 2011.
Case Managers (Transition Planning)

Case managers are designated by principals and they assume the major responsibility for co-ordinating the transition planning process. The educational activities of the student should be infused with transition planning. Principals should assign school staff (ex: student services teacher, classroom teacher, counsellor,) who have responsibility for the educational programming of the student as the case manager, unless another professional is more appropriate. Specific roles of case managers in transition planning include:

- scheduling and facilitating transition planning meetings
- determining graduation dates along with students, parents or legal guardians
- determining members of transition planning teams in consultation with students and parents
- facilitating agreement about the roles and responsibilities of members
- monitoring implementation of transition planning
- maintaining transition planning documents (ex: student assessments, transition planning file, documentation of the plan, meeting notes and other related materials)
- updating plans annually and keeping pupil files current
- maintaining communication with team members, students, parents or legal guardians
- helping the student and parents find services and resources available in the community

Teachers

Students’ educational programming should be a part of the transition planning process. The commitment and collaboration of teachers (resource teachers, special education teachers, classroom teachers, subject teachers, guidance counsellors) who are involved with the students are critical. Teachers’ roles may include:

- assessing the student’s strengths, needs, interests and performance
- making connections between the transition planning goals of the students with their educational goals
- to help students who want post secondary education identify the requirements and prepare accordingly

School Division - Student Services Staff

Student services staff who are closely involved with transitioning students may become members of the transition planning team. They may include speech and language pathologists, occupational therapists, social workers, psychologists, etc. They may:

- identify specific ongoing needs of the student including service requirements
- provide assistance to increase independence and potential of the student to successfully adapt to and maintain a more independent adult life

For information on the transfer of a pupil file and continuation of transition planning when a student changes schools or school divisions, see Appendix B.

For transition checklists – see Appendix C

For information on the transfer of a pupil file and continuation of transition planning when a student changes schools or school divisions, see Appendix B.

For transition checklists – see Appendix C

For information on Appropriate Educational Programming – high school – see Appendix D
Interactive Roles and Responsibilities of Community Workers from: Manitoba Family Services and Housing, Regional Health Programs/Services and Child and Family Services Agencies

**Children’s Services Workers**

Workers from Manitoba Family Services and Housing, services provided by regional health authorities and child and family services agencies who are involved with the student, should participate in the transition planning process until the team agrees that a transfer to appropriate adult services is completed.

**Children’s Special Services**

Manitoba Family Services and Housing’s Children’s Special Services (CSS) program provides services and supports to birth, extended or adoptive families who are raising children with developmental and/or physical disabilities. Services and supports are available through regional offices that are located throughout the province.

The roles of the Children’s Special Services in the transition planning process may include:

- informing the family about the transition planning process and discussing potential adult service options and eligibility requirements (EIA, VR, etc.)
- completing referrals for appropriate adult services which include supporting documentation/current assessments in collaboration with the family and school
- attending school transitional planning meetings
- connecting adult service worker(s) to the family when eligibility is confirmed
- participating in school transitional planning meetings to ensure continuity
- working with adult service workers to provide ongoing planning and referrals

**Child and Adolescent Community Mental Health Workers**

The roles of child and adolescent community mental health workers, from services provided by regional health authorities may include:

- attending transition planning meetings to provide current information to the team on available services and supports
- helping students, parents, school teams and support networks explore and determine appropriate adult supports and residential options
- making referrals to appropriate programs for adults within recommended time lines
- connecting with assigned adult services workers to co-ordinate supports and services
- helping students and families find potential resources in collaboration with adult services workers and school teams

**Child and Family Services Workers**

The roles of the child and family services agency workers may include:

- attending transition planning meetings to provide current information to teams about available services and supports
- helping students, parents, school teams and support networks find appropriate adult supports and residential options
- making referrals to appropriate programs for adults within recommended time lines
- connecting with assigned adult services workers to co-ordinate supports and services
- helping students and families find potential resources in collaboration with adult services workers and school teams
**Adult Services Workers**

Adult services workers from Manitoba Family Services and Housing, designated agencies and regional health authority programs/services must be involved in transition planning. One or more of the following programs may be considered, depending on the needs of the student:

- Employment and Income Assistance
- Supported Living Program
  - Day Services
  - Residential
- Vocational Rehabilitation Program
  (through Manitoba Family Services and Housing; or designated agency, CNIB, Society for Manitobans with Disabilities, Canadian Paraplegic Association Inc.)
- Community Mental Health Services
- Home Care Program

Support programs determine the student’s eligibility for services. Once eligibility for a support program is determined and the availability of the program is confirmed, the roles of the adult worker may include:

- providing information to students, parents and school teams on adult programs and services (ex: residential, vocational and recreational) available in the community
- making referrals to appropriate community adult programs and services and needed resources
- ensuring wherever possible that adult services are in place for students when they graduate
- working with students, parents and school teams in annual transition planning meetings as necessary (at least one annual transition planning meeting before assuming case responsibility)

**Community Service Providers**

Community service providers include government funded community organizations that may provide direct services for those eligible for adult supports. Community service providers may help transition planning teams by:

- attending transition planning meetings as required
- presenting specific information to teams about their services
- assisting the team in determining the knowledge and skills critical for the student to transition successfully to adult supports (suggestions for high priority outcomes)
- providing direction for students and planning teams in preparing for, obtaining and maintaining employment (through assessment and assistance in developing work training outcomes and methods)
ADULT SUPPORT PROGRAMS AND SERVICES

Adult Support Programs and Services Administered by Manitoba Family Services and Housing or Designated Agencies

Adult supports for individuals with exceptional needs may be provided by Manitoba Family Services and Housing through regional offices or through designated agencies including:

- Employment and Income Assistance
- Supported Living Program
  - Day Services
  - Residential
- Vocational Rehabilitation

These programs may include assessment, planning, information, referral, guidance, counselling, treatment, skill development and resource development.

There are eligibility requirements for adult support services. Applicants must be Manitoba residents who are Canadian citizens or legally entitled to live and work in Canada. A registered member of an Indian Band in Manitoba must have established a permanent residence off-reserve before a referral or request for services.

The Student, along with their transition planning teams should contact their regional service centres early in transition planning for complete details on available programs, including eligibility requirements.

**Employment and Income Assistance (EIA) for Persons with Disabilities**

Employment and Income Assistance is provided through regional offices of Manitoba Family Services and Housing.

**Applicant must:**
- have a documented mental, learning, physical, psychiatric or sensory disability
- live in the community or in a long-term or chronic care facility
- need financial assistance to meet his/her needs

**Supports Available**

Employment and Income Assistance includes the following services for eligible participants:

- Income Assistance: provides funds or services to help meet a person’s basic needs, including a living allowance, an allowance for shelter (rent, room and board, residential care charges) and essential health services. (Note that health services through EIA cover the cost of essential health needs, including drugs, dental services and optical supplies)
- Income Assistance for Persons with Disabilities: provides an additional monthly financial benefit to assist people with disabilities with the additional cost of living with a disability in the community.
- Work Incentive Program: allows program participants to keep a portion of their earned income and still receive benefits from the Employment and Income Assistance Program. Under this program, recipients will always have more money if they work, than if they do not.

**Timelines for Referral and Service Provision**

An in-person application may be made at age 18.
**Supported Living Program (SLP) – Residential and Day Services**

Services are co-ordinated through community service workers to meet the unique needs of each individual. Supports and services are accessed through regional offices across the province as available.

**Applicants must:**
- have documented, significantly impaired intellectual functioning accompanied by impaired adaptive behaviour existing before reaching the age of 18
- be a Canadian citizen or adult legally entitled to permanently remain and work in Canada and a resident of Manitoba

**A. Residential Services**

Residential services include a range of supports to help individuals live in the community. Options include:
- independent living with supports – provides skill development and support enabling adults to live on their own
- family home – supports are provided so an individual can live with parents or extended family
- residential care facilities – operated by an agency or private operator to provide accommodation, care and support consistent with individual needs

A self-directed program, In the Company of Friends, which links participants with volunteer support networks in the community, may also be available.

**B. Day Services**

Day services include a range of supports and training to help individuals participate in the community through one or more activities:
- supported employment and follow-up services to support individuals in paid jobs in community settings
- vocationally focused services to help develop, maintain and enhance vocational and social skills, provided in a day service facility or community setting
- personal development services to develop, maintain and enhance an individual’s personal care and social skills, emotional growth, physical development and community skills

**Age for Service Availability:**
- residential services: at age 18
- day services: July of the calendar year an individual turns 21

**Vocational Rehabilitation**

Vocational Rehabilitation services may be delivered or co-ordinated by:

1. **Provincial Government** – Vocational rehabilitation counsellors are located in the Manitoba Family Services and Housing (FSH) regional offices in rural and northern Manitoba and in community area offices in Winnipeg. FSH provides vocational rehabilitation services to persons with mental, learning or psychiatric disabilities.

2. **Regional Health Authorities** – Mental health workers are located across the province thorough RHAs and provide services to persons with psychiatric disabilities. Some regions also employ employment development specialists.

3. **Designated Agencies** – Some agencies receive provincial funding through FSH to provide services to persons with specific disabilities. The three designated agencies are:
   a. Society for Manitobans with Disabilities Inc. – provides vocational services to persons with a physical disabilities including the Deaf and hard of hearing (excluding persons with a visual disability or spinal cord injuries).
b. Canadian Paraplegic Association – provides vocational services to persons with spinal cord injuries.
c. CNIB – provides vocational services to persons with visual disabilities.

Applicant must meet specific eligibility criteria and be able to enhance his/her ability to regularly pursue employment through voluntary participation in rehabilitation/ training process appropriate for his or her individual needs and vocational goals.

Service Options
The Vocational Rehabilitation Program helps participants develop an appropriate vocational plan based on their unique needs, interests and abilities. The implementation of the individual vocational rehabilitation plan may involve a single referral or a multi-year training plan, including a variety of services, as follows:

- School-to-Work Transition Program: provides funding to purchase supports designed to facilitate the transition of eligible students from school to paid employment.
- Post-Secondary Education and Training: may provide funding support to assist individuals to enrol in University or Community College programs.
- Vocational Training: through a range of Assessment and Employment Services as well as training on the job.
- Support Services: such as building or vehicle modification, technical aids or devices, special equipment, transportation, tutors, interpreters, sign language or note taking are also made available to assist or enable the individual to pursue training or employment goals.
- Job Placement: assistance with resume preparation, making contacts with job placement services, job referrals and job development services.
- Employment Support Services: are time limited and may be funded to support individuals with work-related issues impacting on the ability to maintain employment.

Age for Service Availability:
- Age 16 or over and not attending school.

Inquiries for Employment and Income Assistance, Supported Living Programs, Vocational Rehabilitation Program, and other services from FSH:

Contact information for FSH regional offices is available at: www.gov.mb.ca/fs/locations/ruralnorthern.html (rural or northern regions of Manitoba) or www.gov.mb.ca/fs/locations/winnipeg.html (Winnipeg).

Inquiries for vocational rehabilitation services from the designated agencies should be directed to:

- Society for Manitobans with Disabilities: www.smd.mb.ca/contact_us.aspx
- The Canadian Paraplegic Association: www.cpamanitoba.ca/


**Adult Support Programs Funded by Manitoba Health and Healthy Living**

Adult support programs may be available through regional health authorities (RHAs) and include the Community Mental Health Services and Home Care Program.

RHAs deliver mental health services including planning, delivery and ongoing management of services in Manitoba. Community mental health workers provide services through the RHAs and Community Mental Health Services.

Questions about the responsibilities at the local level can be directed to the regional health authorities at [www.gov.mb.ca/health/rha/contact.html](http://www.gov.mb.ca/health/rha/contact.html)

**Community Mental Health Services**

Community mental health provides comprehensive assessment, case management, rehabilitation/treatment, counselling and crisis intervention, community consultation and education.

Community mental health services staff help people with mental illness develop coping and living skills. They also help them find other community services they may need.

**Eligibility for Community Mental Health Services**

Each RHA has its own eligibility criteria and intake process. However, there are some common standards:

- Services are for individuals with mental health problems that compromise their capacity to participate in major life activities such as family life, employment, education, community or social relations (e.g., schizophrenia, major affective disorders, bipolar disorders, anxiety disorders).
- Participation is voluntary and requires the informed consent of the individual for referral.
- Services are usually for individuals 18 years of age or older, who are residents of the regional health authority.

RHAs can set their own eligibility criteria and intake process. To find out about specific eligibility criteria applicants or their designates must contact the RHA where the student resides.

In addition to the services provided by community mental health workers, RHAs may have a variety of additional programs. It is important to consult the home region of the student about the services available locally.

**Timelines for Referral and Service Provision**

- Referral: at age 17
- Potential timeline for service to be available: at age 18 or older

**Home Care Program**

The regional health authorities deliver the Home Care Program including planning, delivery and ongoing management of services.

The RHAs are responsible for:

- accepting referrals and determining eligibility for home care services, based on a multi-disciplinary assessment
- developing a plan of care which takes into account the needs of the individual and family as well as available community resources
- determining the amount and type of services to be provided