Kackaamin
FAMILY DEVELOPMENT CENTRE

Short Program | Adult Application

Program Applying for:

☐ Grief & Loss (family- *Mar. 8-13, 2026*)

www.kackaamin.org T. 250.723.7789 F. 250.723.5926

Kackaamin Family Development Centre sits on Hupacasath and Tseshaht First Nation unceded territories. We walk respectfully with the intention of helping people on their healing journeys, and practice with reciprocity, honest kindness and kind honesty.

Last Updated: 30 Dec 2025

Short Program | Adult Application

****** Please ensure this application is complete and sent with your Intake Checklist ******
****** or your package will be considered incomplete. ******

Dear Applicant,

Thank you for your interest in attending Kackaamin Family Development Centre. Our team is committed to providing a safe space for you to come for healing.

If you feel you may be dependent on using alcohol, opioids or other strong substances, we strongly recommend attending individual treatment prior to attending our programs.

This form is to be completed by the Applicant *and* Referral Worker. Please read and sign as indicated.

Please fax pages 4 – 9 to us at 250-723-5926.

Once all pre-admission requirements are met, the Intake Coordinator sends a confirmation letter to Client and Referral Worker including information:

- Session Dates
- What to Pack
- General Guidelines

For more program information, please visit our website: http://www.kackaamin.org.

Sincerely,
Kackaamin Family Development Centre

Applicant Initial _____ *Referral Worker Initial* _____

Section 1: Readiness

The Restoring Balance: Grief & Loss program is intensive and requires stability and sobriety. Applications will be considered if applicants are:

- ✓ Not using alcohol, marijuana, or illicit substances regularly
- ✓ Parents bringing children have custody and have been living with the children
- ✓ Support systems are in place for counselling after program completion
- ✓ Other concerns can be managed safely with Kackaamin resources, such as health/mobility

Applications cannot be considered if:

- ☐ Detox and withdrawal support is required (including short-acting OAT)
- ☐ Adults with history or convictions of sexual violence are unable to attend. Please connect with our Rebuilding the Circle (RTC) team for treatment options.
  --If there is Domestic Violence (or risk of) with any of your family members who are applying, please set up a time with us to discuss options.

Section 2: Informed Consent

Please check after discussed to acknowledge:

- ☐ **Safety & commitment** to healing is required
- ☐ **No cell phones, smart watches, laptops, gaming consoles allowed**
- ☐ Clients **must** stay onsite for the duration of the program.
- ☐ Children **must** be living with the parents/applicants prior to attending the program and after program. **Children and youth are to be supervised at all times.**
- ☐ **Shared custody:** other parent/caregiver(s) must be informed of the child(ren)'s attendance to the program.
- ☐ Clients must arrange their own travel to Kackaamin and arrive on Intake Day between 12pm-4pm. If discharged or they leave early, the client is responsible for their return travel arrangements.
- ☐ **Possible Reasons for Early Discharge from Program:**
  - Substance use
  - Unable or unwilling to participate in program/Program Guidelines
  - Ongoing bullying or aggression toward others, violence, damage to property, etc.
  - Concerns for safety and needs that cannot be met at Kackaamin
  - Incorrect/inaccurate information on application that impacts others safety

Applicant Initial _____ *Referral Worker Initial* _____

Section 3: Applicant Information

Information required for our reporting and safety planning:

Adult Application			Date:
Legal Last Name:	Legal First Name:	Alias/Goes by:	
Date of Birth: *YYYY/MM/DD* _____/_____/_____	Self-Identified Gender:	Personal Health Number:	
Aboriginal Ancestry? ☐ YES ☐ NO	First Nation: Status #:		On-reserve ☐ Off-reserve ☐
Contact Information			
Home Address:		Email: Phone:	
Mailing Address: *Same as Home Address:* ☐		**Emergency Contact**: Relationship to Client: Emergency Contact #:	
General Info			
School attendance ☐ Elementary ☐ Some high school ☐ Completed high school ☐ Additional training/Education ☐ College/University			
☐ Residential School (IRS) ☐ Indian Day School (IDS) ☐ Parent(s) or Grandparent(s) attended IRS ☐ Parent(s) or Grandparent(s) attended IDS			
Are you employed? ☐ No ☐ Part-time ☐ Seasonal ☐ Full-time ☐ Income Assistance ☐ Disability ☐ Other:			
Family Relationships			
Marital Status: ☐ Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Other:			
Current Living Arrangements: ☐ With my children & partner ☐ Single Parent ☐ Alone ☐ With extended family ☐ Recovery home ☐ Shelter ☐ Other			

The following information is to help us plan your care:

Children Attending (Attach applications)		
Name, Age	**Relationship to Applicant:**	**Living With Applicant?** Y/N

Applicant Initial _____ *Referral Worker Initial* _____

Guardianship		
Are MCFD or Delegated Aboriginal Agencies involved at any level?	☐ Yes ☐ No	If yes, please describe: Most recent Family Plan attached? ☐Yes ☐No
Are any of the children in care?	☐ Yes ☐ No	If yes, please describe: Most recent Family Plan attached? ☐Yes ☐No
Do you have any other children (e.g. adults, children not living in the home)	☐ Yes ☐ No	If yes, please describe:
Attach any relevant documents, orders, correspondence	☐ Supervision Order attached ☐ Safety Plan attached ☐ Shared guardianship- signed letter attached	

Wellness and Mobility Information

Are there any physical challenges or chronic health conditions that require special care? *Please specify*:

Remember, we encourage families to bring another family member as a Support Person to help if needed!

Mobility Challenges? ☐Yes ☐No Info: | Require a whelchair-accessible unit? ☐Yes ☐No

Reading/Writing/Hearing Challenges? ☐Yes ☐No Describe:

Any mental health diagnoses? ☐ N/A ☐ PTSD ☐ Depression ☐ Anxiety/Panic disorders ☐ ADHD ☐ FAS/FAE ☐ Brain/Head injury ☐ BPD ☐ Psychotic disorder ☐ Other:

Any history of: ☐ Suicidal Ideation ☐ Self-Harm ☐ Attempted Suicide – last attempt: _____ ☐ N/A

Do you have any losses in the past six months or so?

Legal History

Do you have any legal orders or legal involvement? ☐ No charges or convictions –*skip to next section.*

☐ Yes -- Copy of applicable Legal Order and PO contact information is <u>required</u> to review application

☐ Release Order ☐ Upcoming court date(s): _____

☐ On Probation/Parole: PO Name: _____ Number: _____

E-mail:_____

City: _____

☐ <u>Prior</u> charges relating to: ☐ Violence ☐ Sexual ☐ Drug-related ☐ Involved a minor ☐ Involved a partner

Referral Information

Referral Worker/Counsellor Name:	Title:
Fax:	Email:

_____ _____

Referral Worker Signature **Date**

Applicant Initial _____ *Referral Worker Initial* _____

Consent *(please list support workers that may help plan your care)*

Consent for the Release of Confidential Information:

I, (applicant name) _____ hereby give permission for the Intake staff at Kackaamin Family Development Centre to contact my referral worker, counsellor, social worker, doctor/nurse, and my Bail/Probation Officer as listed below for the release of pre-treatment planning information.

Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail

Acknowledgment and Assumption of Risk

I understand that with the sharing of information, there is a rare risk of the data transfer being interrupted by persons other than the intended recipient. I understand that in the case of missing transferred data, this could result in an application not being deemed complete by the Kackaamin Intake team, leading to a delay or omission of service.

I understand that Kackaamin staff engages in case conferencing for the benefit of my treatment and healing.

I understand that the information collected and required for Kackaamin Intake will be stored and handled in a confidential manner, and that I may apply to access within the amount of time identified by the Freedom of Information and Protection of Privacy Act.

Release of Liability, Waiver of Claims, and Indemnity Agreement

I hereby agree as follows:

To waive all claims that I have or may have in future against Kackaamin Family Development Centre, its agents, directors, employees and representatives and other participants, all of whom are hereafter collectively referred to as Releases.

I have read, understood and agree with the statements in the Acknowledgement and Assumption of Risk portion of this document, and by assuming and acknowledging this risk, I completely absolve all Releases from any and all liability for loss, damage, injury or expense that I may suffer, that a third party may suffer or that my next of kin may suffer as a result of the release of information by the Releases, due to any cause whatsoever.

In entering into this agreement, I am not relying upon any oral or written representation or statements made by the Releases.

I have read and understood this agreement, and I am aware that by signing this agreement I am waiving certain legal rights which I or my heirs, next of kin, executors, administrators or assigns may have against the release.

Questions regarding the collection of this information can be directed to the Intake team @ 250-723-7789.

_____ _____

Applicant Signature **Date**

Applicant Initial _____ *Referral Worker Initial* _____

Section 4: Counselling Summary

Counselling Summary		*(To be completed by the Counsellor) p.1/1*
Date:	Applicant Name:	D.O.B.:
	Counsellor Name:	Contact Info:

This form is to support the Applicant prepare to attend our 5-10 day trauma healing program.

- Individual treatment is strongly recommended for individuals prior to attending Kackaamin's trauma healing programs, especially when there are substance addictions.
- We strongly suggest that attendees have counselling support after attending to ensure a continuum of care, as the healing sessions at treatment can reveal vulnerabilities requiring additional or ongoing support.

Please complete the following information with the Applicant to support planning and safe delivery of service at our establishment.

Has the Applicant completed *pre-treatment* appointments with you? ☐ No
☐ Yes, dates of sessions in the past 3 months:

Does the applicant have a *post-treatment* appointment set? ☐ No ☐ Yes, date:

Check all applicable boxes: ☐ PTSD ☐ Anxiety/Panic disorder ☐ Anger/Acting out ☐ Grief & Loss
☐ Sexual trauma/abuse ☐ Family violence ☐ Family trauma ☐ Foster care
☐ Violence toward children or partner ☐ Other:

Is the Applicant willing to partake in healing through a **group setting**? ☐ No ☐ Yes

At this moment, do you perceive the Applicant is ready to attend group healing session? ☐ No ☐ Yes

Summary of strengths:

Counsellor Signature: _____ Date: _____

Thank you! Your information will help us plan client supports and resources for their time here.

Applicant Initial _____ *Referral Worker Initial* _____

Section 5: Medical Assessment (2 pages)

Medical Assessment (*To be completed by a physician or nurse)*		p.1/2
Date:	Applicant Name:	D.O.B.:
	Personal Health Number:	Allergies:
	Pharmacy:	Pharmacy #:
	Physician:	Physician #:

The Applicant named above is applying to attend a 5-10 day residential treatment program. We strongly suggest that this is completed by a Medical Personnel (doctor, nurse) that regularly sees the Applicant.
Please complete the following information with the Applicant to support planning and safe delivery of service at our establishment.

Medications

Please attach a list of current medications including dose and reason for taking

1. Have you recently completed a medication review with the Applicant? ☐ No ☐ Yes
2. Is the Applicant taking medications as prescribed? ☐ No ☐ Yes

Substance Use and Withdrawal Support

Our Family Program requires Applicants to be detoxed and stabilized prior to attending. This is so they can complete residential trauma healing safely.
We suggest Applicants who are dependent on substance(s) attend Individual Treatment *prior* to attending with their children/families.

Please screen your client for withdrawal management needs and refer to community services if needed.

1. Withdrawal management required? ☐ No (*skip to question 3*)
   ☐ Yes ☐ Referred to community agency
2. Is the Applicant accessing Opiate Agonist Therapy? ☐ No (*skip to question 3*)
   ☐ Yes

Prescribing Physician/NP:	Ph:	Fax:
Specify Replacement Type (e.g. Methadone, Suboxone, Sublocade, etc.):		Initial Dose:
		Current Dose:

3. Does the Applicant take prescribed medical marijuana (including CBD or THC)? ☐ No ☐ Yes, for:

Applicant Initial _____ *Referral Worker Initial* _____

MEDICAL HISTORY	Comments
Does the Applicant have any communicable diseases? ☐ No ☐ Yes	
Does the Applicant have any history of head trauma or cognitive impairment? ☐ No ☐ Yes	
Does the Applicant have a history of seizures? ☐ No ☐ Yes	
Does the Applicant have any chronic illnesses or conditions? Mobility impairments? ☐ No ☐ Yes	
Is the Applicant pregnant? ☐ No ☐ Yes	(If yes, how many weeks?)

TB SCREENING *(if entering into Panorama, refer to Panorama Entry Guide)*

This TB screening is to rule out **active TB**. Latent TB screening is not required for attending our treatment centre, but it may be beneficial to the Applicant and can be done at a later date.

TB Symptom Assessment

☐ Fever	☐ Cough (>3 weeks)	☐ Hemoptysis
☐ Chest pain	☐ Short of breath	☐ Fatigue
☐ Night sweats	☐ Lymphadenopathy	☐ Other:
☐ Unexplained weight loss	☐ Sputum production	

Has the Applicant had any recent exposure to TB? ☐ No ☐ Yes | Receiving TB treatment? ☐ No ☐ Yes

***If the Applicant has a cough or other symptoms consistent with active TB, complete TB Screening as indicated by BCCDC and fax to the appropriate services:**

If the Applicant lives:

- In a **BC First Nations community**, fax form to FNHA TB Services: 604-689-3302
- **Urban areas (off-reserve) Island Health:** fax 250-519-1505
- **All other areas, BCCDC**: fax 604-707-2690

TB HISTORY

Has the applicant ever had any of the following (check all that apply):

☐ Positive TST and/or IGRA result ☐ Contact with someone with active TB ☐ Treated for TB

RISK FACTORS

Certain risk factors post a risk of progression from Latent TB to Active TB, or increase the risk of exposure to TB. Check all that apply:

☐ Transplant	☐ Chronic kidney disease/Dialysis	☐ Substance use
☐ Cancer (specify)	☐ HIV	☐ Tobacco use
☐ Immune suppressant medications	☐ Homelessness, underhoused (past or current)	☐ Work or live in a correctional facility (past or current)
☐ Diabetes		

Practitioner Signature: _____ Clinic Name or Stamp:_____

Applicant Initial _____ *Referral Worker Initial* _____