Grief & Loss Application

Applying for:

☐ July 13 - 18

☐ August 10 – 15

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 one of our short programs that acknowledge significant trauma.

This form is to be completed by the Applicant *and* Referral Worker. Please read and sign as indicated. All sections need to be completed and received in full to be considered "complete."

Please **fax pages 2 – 4** to us at **250-723-5926.**

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

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: 11 June 2025

Section 1: Admission Requirements

The following should be in place for client safety and to reduce stress for clients to come do their healing program:

Physical SAFETY:

- ☐ **Detox prior to attending program.** KFDC Programs are for people who **do not require** detox.
- ☐ **Medical** check-up, including up-to-date medications, hearing aids, glasses, etc. if needed.
- ☐ **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.
- ☐ Adults with history or convictions of sexual violence are unable to attend. Please connect with our Rebuilding the Circle (RTC) team for treatment options.

Mental / Emotional SAFETY:

- ☐ Adults must be physically and mentally able to participate in our rigorous **group learning** *(sitting and participating with other clients for 3-4 hour periods at times).*

Emotional SAFETY:

- ☐ **Counselling:** before and after treatment. Attending treatment impacts people in various ways. Having a support network is *needed.*
- ☐ **Continuity of Care**: The Referral Worker should maintain regular pre/post-treatment contact.

Section 2: Informed Consent

Referral Workers: Please check after discussing with Applicant:

- ☐ Faxing applications is the safest way to share your information. Emails across different organizations are not secure *unless* documents are password-protected.
- ☐ **Safety & commitment** to healing is required.
- ☐ Our Intake team will send a Confirmation Package to you and your referral worker once accepted into the program.
- ☐ Shared accommodations (your own bedroom) and meals will be provided by Kackaamin.
- ☐ **No cell phones, smart watches, laptops, gaming consoles allowed**
- ☐ There are landlines in the cabins available for calling out (calls cannot be received at the cabins).
- ☐ Clients **must** stay onsite for the duration of the program.
- ☐ The Client is responsible for their return travel if they leave or are discharged from treatment early.
- ☐ Clients must arrive on Intake Day between 12pm-4pm.

Other:

- ☐ **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 Name: _____ Signature: _____ Date: _____

Referral Signature: _____ Date: _____

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** Name: Relationship to Client: Emergency Contact #:

The following information is to help us plan your care:

Goals
Why would you like attend Kackaamin? Do you have any recent losses?

Wellness and Mobility Information	
Allergies? (medications, foods, etc.): ☐ Epi-Pen	
Medications:	
Are there any physical challenges or chronic health conditions that require special care? *Please specify*:	
Mobility Challenges? ☐Yes ☐No Info:	Require a wheelchair-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:	

Kackaamin
FAMILY DEVELOPMENT CENTRE

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

Substance Use & Treatment History

Have you attended treatment sessions before? ☐ Yes ☐ No

Any concerns about addiction to any of the following?
☐ Alcohol ☐ Marijuana ☐ Other Drug:
☐ Prescription meds ☐ Tobacco ☐ Gambling ☐ Eating ☐ Gaming ☐ Internet (scrolling)
☐ Caffeine/Pop ☐ Sex/Porn ☐ Exercise ☐ Other:

Referral Information (*To be completed by Referral Worker)*

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

We strongly suggest Referral Workers support clients *after* they complete family treatment for a continuum of services. Will you be available to follow up with the applicant? ☐ No ☐ Yes

Referral Worker Signature	**Date**
Applicant Signature	**Date**

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