Kackaamin
FAMILY DEVELOPMENT CENTRE

Returning to the Circle ~ Grandfathers, Uncles & Caregivers Program

Application Package

We are pleased to be a part of your healing journey.

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FAMILY DEVELOPMENT CENTRE

Returning to the Circle ~ Grandfathers, Uncles & Caregivers
Men's Healing Application Package

"Returning to the Circle"- Grandfathers, Uncles and Caregivers August 28- September 8/23

COST: FREE

This program will explore the traditional Indigenous roles of Men in our families and communities. Programming will address multi-generational trauma stemming from the Residential School Legacy. This program will offer a safe space to begin looking at delayed grief and specific traumas (the roots of addiction) through experiential and cognitive processes using culturally relevant approaches.

Participants are asked to refrain from any and all drug and alcohol use during programming. Healing will be based on Traditional culture and ceremony- participants' need to have a clear mind and spirit to connect with the Creator and Ancestors.

All participants will be sharing their accommodations with others. Kackaamin has 2 bedroom, 3 bedroom, 4 bedroom and wheel chair accessible townhouse units. Each unit has one queen bed, and depending on the other units they have twin beds, with bathrooms and full kitchens.

Participants will be confirmed once applications are reviewed by our clinical intake committee.

CELL PHONE USE DURING PROGRAMMING WILL NOT BE ALLOWED.

Kackaamin Family Development Centre Program Guidelines

- Clients must have a minimum 3 weeks of abstinence from any previously misuse substance.
- Smoking is allowed in the designated smoking areas
- Clients are responsible for their own travel arrangements to and from the center
- Arrival time on intake day is between 12:00 pm – 4:00 pm

Please connect with Intake Coordinator, Julie Fontaine, at 250-723-7789 or julie.f@kackaamin.org for appropriate applications for summer programming, and for any questions or concerns related to programming application requirements.

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Grandfathers, Uncles & Caregivers Application

PLEASE PRINT CLEARLY

IDENTIFYING INFORMATION

LAST NAME	FIRST NAME	KNOWN AS
DATE OF BIRTH (YYYY MON DD) ❑ MALE ❑ FEMALE	TELEPHONE	EMAIL
ADDRESS	CITY	PROVINCE / POSTAL CODE
ABORIGINAL ANCESTRY ❑ YES ❑ NO	BAND NAME	ON RESERVE ❑ YES ❑ NO
CARE CARD NUMBER	STATUS NUMBER (10 DIGIT NUMBER)	

PERSONAL HISTORY

EMPLOYMENT STATUS ❑ WORKING ❑ S.A. ❑ E.I.C. ❑ OTHER	MARITAL STATUS: ❑ SINGLE ❑ COMMON-LAW ❑ SEPARATED ❑ DIVORCED

Are you a survivor of Residential School? ❑ YES ❑ NO
Are you a survivor of a Day School Program? ❑ YES ❑ NO
Are you an Intergenerational Survivor of Residential/ Day School? ❑ YES ❑ NO

Substance Use History- Please Indicate Drugs of Choice and Date of Last Use:
(We are collecting this information for program development and client safety while here)

❑ ALCOHOL Date of Last Use:	❑ NON- PRESCRIPTION DRUGS Date of Last Use and Substance:	❑ PRESCRIPTION DRUGS	❑ INHALANTS
ii) Abuse Pattern	❑ DAILY ❑ MOSTLY WEEK-ENDS ❑ BINGE		

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT SURNAME	EMERGENCY CONTACT FIRST NAME	RELATIONSHIP
TELEPHONE	EMAIL	CITY OF RESIDENCE

INFORMATION

Do you have physical limitations that prevent you from doing recreational or cultural activities	❑ YES ❑ NO	Do you require a wheel chair accessible unit?	❑ YES ❑ NO
Do you have any allergies (food, insect, medications) we need to be aware of		Please explain	
I understand and accept I will be placed in shared accommodation	❑ YES ❑ NO	I am committed to complete a structured program process focused on my wellness	❑ YES ❑ NO
I am willing to be involved in all types of intensive activities?	❑ YES ❑ NO	I am willing to participate in First Nations Treatment program components such as sweat lodge, daily smudge, pipe and other cultural ceremonies?	❑ YES ❑ NO
I am willing to put aside all external distractions while in the journey to the wellness program	❑ YES ❑ NO	Have you received the COVID-19 Vaccine?	❑ YES ❑ NO

TREATMENT NEEDS

Have you engaged in healing programs (healing circle, cultural practice, etc.)?:
Trauma Please note any recent or past traumatic events you feel comfortable disclosing at this time.
Specific Treatment Please note any specific goals or needs (i.e. spiritual, mental, emotional, physical) that you have for treatment.
Specific Needs Please note any special needs, physical limitations, or other concerns you may have at our Centre.

HEALTH HISTORY

LAST NAME	FIRST NAME
CARE CARD NUMBER	STATUS NUMBER (10 digit number)
Do you have any Medical Issues or Conditions that we need to know about for your Health and Safety?	

NOTE: If the skin test is required and the results measure larger than 10mm, a subsequent TB chest X-ray must be performed.

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

MEDICATION NAME	CURRENT DOSE	TAKING SINE	PATIENT INTIALS	DATE FINISHED

Acknowledgment

I understand I am providing the following confidential medical information for my personal safety while at Kackaamin Family Development Centre, in case of a medical emergency

CLIENT SIGNATURE DATE

REFERRAL WORKER NAME REFERRAL PHONE:

REFERRAL WORKER SIGNATURE DATE