Kackaamin
FAMILY DEVELOPMENT CENTRE

Rebuilding the Circle

Adult Intake Application Package

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WHAT IS REBUILDING THE CIRCLE?

Rebuilding the Circle (RTC) is a strengths-based continuum of comprehensive treatment services to heal the impacts of sexual harm in Nuu-chah-nulth families and communities. RTC is Quu?as based, trauma-informed, and holistic. We are on a journey of healing for all and restoring the strength of Nuu-chah-nulth communities.

The Rebuilding the Circle treatment model offers programs for those who have been harmed, those who have harmed others, and the impacted family system. The RTC treatment model requires that if a person has harmed others is applying for treatment, that they complete the Restoration Program to address the offending behaviour, before completing a Healing Session to address their own victim trauma.

- **This Application is to be completed and reviewed together by the applicant and referral worker**

- **This Application, and the Intake process will ask potential clients to reflect on how sexual violence has impacted themselves and/or their family system. The wellbeing and safety of potential clients is important. Our team is here to work with the applicant, and their community referral worker/s to create support and safety.**

- **The Rebuilding the Circle team can work with the referral worker and potential client in developing a Wellness Plan to support the wellbeing of the client and/or family system.**

APPLICATION OVERVIEW:

☐ **This Application is to be completed and reviewed by the Referral Worker and the KFDC Intake worker.**

☐ **Please note by submitting an application you are not registered for a program, there is a face-to-face interview that will need to take place before a decision is made to admit you to a program.**

☐ **Incomplete packages will not be held in cue and will not be considered for admission until all required portions are received.**

☐ **Please ensure the medical portion (form found within this application) is completed and signed off by a physician or nurse practitioner and submitted with each application.**

☐ **Each applicant must attach a copy of TB test results to their application to be considered for admission.**

☐ **If this is a session that allows children: All children must be up to date on immunizations to attend our facility and must submit immunization records with their applications.**

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GENERAL INFORMATION:

DATE OF APPLICATION:

Last Name:	First Name:	Alias:

Date of Birth (YYYY/MM/DD): / / Self-identified Gender:	Telephone:	Mobile:
Email Address:	Other:	

Address:	City:	Province:	Postal Code:

Aboriginal Ancestry ☐ YES ☐ NO	Band Name: Band Number:	On Reserve ☐ Off Reserve ☐

Personal Health Number:

Emergency Contact:	Telephone:

Relationship to Client:

FAMILY RELATIONSHIPS:

Current Living Arrangements:

❑ With my family ❑ With extended family ❑ With parent(s) ❑ With friend (s) ❑ Alone ❑ As part of a couple
❑ As a single parent ❑ With partner and kid(s) ❑ Alone ❑ Recovery Home ❑ Homeless ❑ Shelter
❑ Other (*specify):*

Marital Status: ☐ Married	☐ Common-Law	☐ Single	☐ Separated ☐ Co-Parenting	☐ Widowed	☐ Divorced

Is MCFD or DAA 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

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Does the client have other children? (e.g. adults, not living in home)	☐ YES ☐ NO	If yes, please describe:	
Does the applicant have any outstanding child custody issues?	☐ YES ☐ NO	If yes, please describe:	
Does the applicant have a no-contact order with his/her partner?	☐ YES ☐ NO	If yes, please provide date order came into effect:	

Dependent Child (ren): *First and Last Name*:	Age:	Relationship to Applicant:	Consent to attend treatment: *(signature required)*

(For children in care or living with other family members)

Is there a supervision order from a family protection agency?

☐ Yes ☐ No ☐ Not Applicable

(Please attach supervision order/document)

Is there a safety plan from a family protection agency?

☐ Yes ☐ No ☐ Not Applicable

(Please attach safety plan)

FAMILY SUPPORTS

FAMILY STRENGTHS

Are there any physical challenges or chronic health conditions that require special attention in any member of your family? *Please specify*

Will the client require any assistance with reading or writing? ☐ Yes ☐ No

Additional Information:

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FUNDING RESOURCES:

The following will be provided during the duration of the Rebuilding the Circle program:

- Accommodations: for length of program (*4 weeks or 8 weeks*)
- Meals: Monday-Friday (Breakfast, Lunch, Dinner)

The Client is responsible for the following:

- Meals: Weekends (Breakfast, Lunch, Dinner)
- Travel: To and From Program

Contact:
intake@kackaamin.org
Our Intake Team can connect you with resources, to support the client in attending this program

- **ALL FUNDING RESOURCES MUST BE IN PLACE PRIOR TO ATTENDING**

EMPLOYMENT HISTORY:

Source of Income:	☐ Job	☐ Income Assistance	☐ Disability Income

Please select all that apply:

☐ Full time ☐ Seasonal ☐ Retired ☐ Student
☐ Part Time ☐ Temporary ☐ Self Employed
☐ Permanent ☐ Unemployed ☐ Training

EDUCATION STATUS

(Please check the highest level of education)

☐ Elementary (Grades 1-8) ☐ College/Post-Secondary
☐ High School (Grades 9-12) Did client graduate High School? ☐ Yes ☐ No
☐ Trade School (e.g. hairdressing, carpentry)
☐ Adult Dogwood Certificate ☐ University (Bachelor Degree, Masters)

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LEGAL STATUS

Does the applicant have a history with the legal system?

☐ **Yes** ☐ **No**

If yes, complete this section in full. If no, please move on to next section.

Are there any previous charges or convictions? Are there any pending charges or convictions?
If yes, list any upcoming court dates:

If yes, what were the charges (select all that apply):

☐ **Violent** ☐ **Sexual** ☐ **Drug-related** ☐ **Involved a minor** ☐ **Involved a partner**

Are there any current legal orders or legal involvement in place for any reason? ❑

Yes ☐ **No** ☐

If yes, please describe:

Have there been restitution efforts made by the applicant for those who have been harmed? ☐ **Yes** ☐ **No**

If yes, please describe:

Is the applicant currently:

☐ **On Parole** ☐ **Serving a Probation Order** ☐ **Bound by Release Order/ Undertaking (Bail Order)**

If yes, please provide:

Parole/Probation/Bail Officer Name:	
P/P/B Officer Phone:	
P/P/B Officer Email:	
Address:	**City/Province:** **Postal Code:**

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

I, (please print applicant name)_____ hereby give permission for the intake staff at Kackaamin Family Development Center to contact my referral worker and my Parole/Probation/Bail Officer for the release of pre-treatment information, disclosure of progress during treatment and aftercare planning and final discharge report if requested.

_____ _____

Applicant Signature Date

- **THE CLIENT MUST NOT HAVE ANY UPCOMING LEGAL ISSUES/COURT DATES DURING THEIR STAY AT THE RESIDENTIAL COMPONENT OF THE PROGRAM**
- **ALL COURT DATES MUST BE DEALT WITH PRIOR TO ADMISSION TO KACKAAMIN FAMILY DEVELOPMENT CENTRE**
- **A COPY OF THE PAROLE/PROBATION/BAIL ORDER MUST BE INCLUDED WITH THE APPLICATION FOR TREATMENT BEFORE IT WILL BE REVIEWED BY THE KFDC INTAKE COMMITTEE.**

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TREATMENT HISTORY AND NEEDS
MENTAL, EMOTIONAL, PHYSICAL AND SPIRITUAL:

1. Have you participated in community-based substance abuse, mental health programs, or healing programs?
☐ Yes ☐ No
List Programs:

2. Have you attended the following:	**Required to participate in the following while on site:**	
Alcoholics Anonymous	☐ Yes ☐ No	Alcoholics Anonymous/12-step programs
Narcotics Anonymous	☐ Yes ☐ No	Narcotics Anonymous
Other Step programs	☐ Yes ☐ No	
Co-dependents Anonymous	☐ Yes ☐ No	
Self-help	☐ Yes ☐ No	
Cultural Activities	☐ Yes ☐ No	

3. Have you participated in a residential treatment program? ☐ **Yes** ☐ **No**

If yes, please provide treatment history:

Treatment Type	**Type of addiction and/or trauma treated:**	**Year**	**Complete**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. Are you receiving counselling from any counselling resources? ☐ **Yes** ☐ **No**
If "Yes", how many counselling sessions in the last 3 months?
If 'No" will you be seeing a counsellor prior to treatment?

5. Please list any counsellors, social workers, or other services you are being supported by? (Name, Phone Number):

6. Have you been hospitalized because of substance misuse? Yes ☐ **No** ☐
If "Yes", please list date/s:

7. Have you ever been hospitalized for a mental illness by a medical professional? Yes ☐ **No** ☐
Attach assessment if available

8. Does the applicant have a history or have they ever been diagnosed with a mental illness by a medical professional?
Yes ☐ **No** ☐ ***If yes, please select all that apply:***
☐ Depression ☐ Anxiety/ Panic Disorders ☐ ADD/ADHD ☐ Brain/ Head Injury ☐ FAS/ FAE ☐ PTSD
☐ Military/ First Responder PTSD ☐ Other:

10. Does the applicant have a history of: ☐ **Suicidal Ideation** ☐ **Self Harm**
Has the applicant ever attempted suicide? ☐ **Yes** ☐ **No**
If yes, when was the last attempt?

11. Did the applicant attend Indian Residential School? ☐ **Yes** ☐ **No**

12. Is the applicant an intergenerational survivor of Indian Residential School? ☐ **Yes** ☐ **No**

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13. Does the applicant have any chronic or acute medical issues that could affect their participation in the program?
☐ **Yes** ☐ **No**
If yes, please provide details:

14. Does the applicant have any special needs that the treatment center should be aware of? (E.g. visual impairments, hearing aids, etc.)
☐ **Yes** ☐ **No**
If yes, please provide details:

15. Does the applicant have any physical disabilities that the treatment center should be aware of? (E.g. require wheelchair accessible rooms, etc.)
☐ **Yes** ☐ **No**
If yes, please provide details:

16. Please share and spiritual or cultural involvement that the applicant takes part in:

17. Is the applicant willing to respect First Nations healing practices and incorporate spirituality into their healing (e.g. Sweat Lodge, Cedar Brushing, Pipe Ceremony, etc.)?
☐ **Yes** ☐ **No**

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SUBSTANCE USE HISTORY:

Please circle primary drug(s) of choice

Drug Type	Est. Age of First Use	How Often (rarely, occasionally, weekly, daily)	Amount/ Quantity Used	Date of last use
Alcohol				
Amphetamine				
Cannabis				
Crystal Meth				
Crack Cocaine/ Cocaine Powder				
Hallucinogens				
Heroin				
Inhalants				
Opiates				
Opioid Agonist Therapy				
Prescription Drugs				
Tobacco				
Process addiction (e.g. gambling, eating)				
Other (specify):				
Other (specify):				

INFORMED CONSENT

I, **(Client's Name, PLEASE PRINT) _____,** consent to attend KFDC and have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points:

Please initial in each box below:

1. _____	I consent to the Intake Coordinator contacting referral agencies, such as Parole/Probation/Bail Officers, Medical Practitioner's, Social Workers etc. to obtain clarification on information included in this application for treatment.
2. _____	I understand if I have legal issues, a copy of the probation order must be submitted with the application for treatment, and **ALL** pending court dates must be dealt with prior to admission to KFDC.
3. _____	I understand the Intake Coordinator will notify my referral worker by letter to confirm my acceptance to treatment.
4. _____	While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.
5. _____	If on provincial assistance, I agree the Intake Coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker.

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6. _____	I understand the importance of being free from and have taken care of all outside business, which will take my attention away from the treatment program.
7. _____	I understand if I am discharged or voluntarily leave treatment, I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.
8. _____	I understand that if I abuse substances while in treatment it may result in my immediate dismissal from the program, with recommendations to a different "Individual" treatment program.
9. _____	I understand that Kackaamin staff engages in case conferencing for the benefit of treatment and healing.
10. _____	If accepted, I consent for the Counsellor to confer with my Parole/Probation/Bail Officers, if applicable, regarding my progress and clarifying any details.

Consent to Release Confidential Information

I, *(Client's signature)* _____ hereby give permission for KFDC staff to contact the referral worker(s) listed below for the release of information in regard to pre-treatment conference call, process during treatment, aftercare planning, and Final Discharge Report.

I, *(Client's signature)* _____ release KFDC from any casual liability in the event that my personal vehicle is damaged or stolen while parked KFDC property.

Referral Worker Name:	
Alternate Worker Contact:	
Organization/Agency Name:	
Address:	
Email:	
Business Phone:	
Business Fax:	

_____ _____

Client's Signature **Date**

_____ _____

Referral/Alternate Worker's Signature **Date**

(The alternate contact person is for confirmation or admission process only – the alternate contact will not be included in the release of confidential information prior to, during, or after treatment). The client may change the name of the person to receive the Discharge Summary at any time. It is up to the client to inform their referral worker of the change. ****NOTE: THIS FORM IS APPLICABLE FOR ONE YEAR AFTER THE DATE SIGNED.**

Please return to:

intake@kackaamin.org
Kackaamin Family Development Center
PH: 250-723-7789
Fax: 250-723-5926

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REFERRAL INFORMATION
TO BE COMPLETED BY REFERRAL WORKER

Referral Worker/Counselor Name: _____

Title: _____

Agency: _____ Tel #: _____ Cell #: _____

Fax #: _____ Email: _____

Address: _____

Has the client completed **minimum of six (6) pre-treatment appointments**? ☐ Yes ☐ No

Please list dates: (*YYYY/MM/DD*)

_____/_____/_____ | _____/_____/_____

_____/_____/_____ | _____/_____/_____

_____/_____/_____ | _____/_____/_____

Is the client receiving counselling from you? ☐ Yes ☐ No

*****If yes- please review and complete "Counselling Summary and Involvement"- addendum to this application.**

CLIENT AUTHORIZATION

I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Kackaamin Family Development Centre.

_____ _____
Client Signature YYYY/MM/DD

_____ _____
Referral Signature YYYY/MM/DD

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MEDICAL ASSESSMENT
TO BE COMPLETED BY MEDICAL PERSONNEL
(E.G. PHYSICIAN, NP, RN, LPN)

PLEASE PRINT CLEARLY

Date of Assessment/ Referral:	Are you the applicant's regular Physician/ Nurse? Yes ☐ No ☐
Applicants Name:	Date of Birth:
Personal Health Care Number:	Status Number:

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (applicants name), hereby request and authorize _____ (Physician, Nurse Practitioner, Registered Nurse or LPN name) to release medical information pertaining to myself to Kackaamin Family Development Center and to my referral worker acting on my behalf (listed above).

_____ _____
Applicant's Signature Date

_____
Medical Personnel's Position/Title

_____ _____
Physician, Nurse Practitioner, RN or LPN Signature Date

*****Note: This form is applicable for one year after signed and dated. The Applicant may change or revoke this release at any time by giving notice to the treatment center in writing. Please complete with applicant*****

Specify any dietary requirements) allergies, intolerances, diabetes, etc.):

Current Medications (Names)	Dose (ml/ng)	Reason for Taking:	How long has patient been taking?

1) Have you reviewed client's medications personally? Yes ☐ No ☐

2) Does the applicant take prescribed narcotics or opioid medications? Yes ☐ No ☐
If yes- what for, what type and how often?

3) Does the applicant take prescribed medical marijuana in any form or oils containing CBD or THC? Yes ☐ No ☐
If yes- what for, what type and how often?

4) Is client taking all medications as prescribed? Yes ☐ No ☐

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MEDICAL HISTORY	COMMENTS
Does the applicant have any communicable diseases? Yes ☐ No ☐	Please Specify:
Has the applicant been tested for Tuberculosis? Yes ☐ No ☐ **(Note: a TB test is required for Admission.)**	Date of test: _____ Results: Negative Positive **Please attach test results and, if positive, chest x-ray results**
Does the applicant have any head trauma or cognitive impairment? Yes ☐ No ☐	Please Specify:
Does the applicant have a history of seizures? Yes ☐ No ☐	Type of Seizures- Please Specify: Date of last seizure:
Does the applicant have any chronic illnesses or conditions? Yes ☐ No ☐	Please Specify:
Does the applicant have any cardiovascular disorders or conditions? Yes ☐ No ☐	Please Specify:
Does the applicant have any allergies? Yes ☐ No ☐ Please Specify:	Does applicant require an Epi-Pen or Ana-Kit? Yes ☐ No ☐ *****NOTE- clients are responsible for their own epi-pens and Ana-Kit's- Kackaamin DOES NOT supply*****
Is the applicant pregnant? Yes ☐ No ☐ N/A ☐	If yes, how many weeks.
Is client currently receiving specialized medical care? E.g. injections, dialysis, wound care, physio, chiropractor, etc.	Please specify:
Please provide blood pressure for applicant.	
Please provide resting heart rate for applicant.	

ANY ADDITIONAL COMMENTS OR CONCERNS:

Please return to:
intake@kackaamin.org
Kackaamin Family Development
Center PH: 250-723-7789
Fax: 250-723-5926

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COUNSELLING INVOLVEMENT AND SUMMARY TO BE COMPLETED BY CURRENT COUNSELLOR		
Date of Form Completion:	Counselor's Name:	Title/Position:
Organization/Agency Name:	Email:	Fax:
Address:	City, Province Postal Code	
Does the applicant have a **post-treatment appointment** set? ☐ Yes ☐ No If yes, date: _____		
Has the applicant completed the **minimum of six (6) pre-treatment sessions?** ☐ Yes ☐ No		
Please provide all counselling session dates in the last 3 months:		
Clients Presenting Problem?		
Summary of Issues Being Addressed in Sessions: (please use additional paper and attach to this form if needed):		

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