INDIGENOUS FAMILY REUNIFICATION PROGRAM (INTAKE ASSESMENT)

Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *Province* *Postal Code*

Phone: _____ Email _____

Age:____ Date of Birth: _____

AB Health Number: _____ Treaty No.:_____ Sin Number:_____

Do you define yourself as: *(Mark with a "X")* **Aboriginal Treaty Status:** **Aboriginal Non-Status :** **Inuit :** **Metis :**

Emergency Contact Info:

_____
Last ***First***

_____
Phone: ***Email:***

Reason for Seeking Indigenous Family Reunification Program?

_____
_____

Are you involved in Cultural/Spiritual Activities?

_____
_____

Addiction History

Primary Substance: _____ Pattern of Use: _____

Age First Used: _____ Last Day of Use: _____

Secondary Substance: _____ Pattern of Use: _____

Age First Used: _____ Last Day of Use: _____

Longest Period of Sobriety: _____ When? (Dates): _____

What worked during this period? _____

What led to your Relapse? _____

Have you been to Treatment Before? _____

Family Status

Partnership Status: (Mark with an X) **Common Law:** **Married:** _____

Are you Pregnant? _____ How Far Along: _____

Are Children living with you? _____ Status of Children Living Arrangements: _____

Is Father/ Mother involved? _____ Is CFS Involved? _____

When was the last time you parented your child together? _____

How long have you and your partner been together? _____

What supports do you have: _____

Are there any current safety concerns from CFS? _____

Please list any court orders in place: _____

_____

If CFS is involved, what role do they have? **(Family Enhancement) (Supervision Order) (TGO) (PGO)**

Is there any no contact orders in place with you, your spouse, or children involved in this application? YES / NO

Are you applying as a couple only? YES / NO

Please list the names of any children who would be involved in this program if any?

1) _____ Age: ____

2) _____ Age: ____

3) _____ Age:____

Do you consent to participate in this program to assist with your family's healing? YES / NO

Name: _____ Date: _____

Signature:_____

Housing Status

What is your housing status?

Homeless_____ Detox_____ Hospital_____ Shelter_____

Incarcerated_____ Couch-Surfing_____ Friends_____ Family_____

Rent Home_____ Own Home_____

Financial Status

Indicate Financial Status: AISH_____ Alberta Works_____ EI_____ Pension_____

Self-Employed____ Company Benefits_____ Child Maintenance____

Other (Please Indicate) _____

If Alberta Works,
Please List Contact
Info Of Benefits worker: _____ Phone_____
Last First

Email_____

Physical Health

Are you currently on any medication? YES / NO

_____
Medication Name Dose Reason

_____
Medication Name Dose Reason

_____
Medication Name Dose Reason

Do you have
Any health restrictions? YES / NO _____
If yes, please describe:

Do you have
Any allergies? YES / NO _____
If yes, please describe:

Are you on: **Suboxone** **Naltrexone** **EpiPen** **Other:**_____

Are you able to participate in
Any of the following?
(Mark with an "X")

Daily Walks (1 hour) ____ Swimming/Aqua size____ Yoga____ Gym Activities_____

Do you have
Any dietary restrictions? Yes / NO

_____
If yes, please describe:

Have dietary restrictions
Been confirmed by your doctor? YES / NO

Do you smoke
Cigarettes or vape? YES / NO

Mental Health

Do you have a mental health diagnosis? YES / NO

_____
If yes, when were you diagnosed?

Are you medicated?
For any diagnosis? YES / NO

_____
If yes, describe medications:

Do you have a
History of suicide attempts? YES / NO

_____
If yes, how many attempts:

_____
_____
List date(s) of attempt(s)
and results:

Do you have a
History of self-harm? Yes / NO

Please explain?
_____
_____
_____
_____

Trauma History

Is there a history of Domestic Abuse in your Immediate Family? YES / NO Sexual Abuse? YES / NO

Do you have a History of Domestic Abuse Against you? Yourself? YES / NO Currently? YES / NO

Have YOU been Abusive in a Domestic Relationship? YES / NO Currently? YES / NO

Have you Experienced Trauma in your life? YES / NO / UNSURE

Please list the type of Trauma/ when and how It is affecting you now:

Criminal History

Do you have any Outstanding legal Charges? YES / NO If yes, indicate any pending charges?

Do you have any Upcoming court Appearances? YES / NO If yes, indicate the DATE(S) of court appearances?

Do you have a History of Violence-related Charges? YES / NO If yes, indicate past charges, and when?

Have you ever been convicted of sexual offence or Arson Yes/ No

Post-Treatment

What is your Plan after graduation from IFRP

_____
_____
_____
_____
_____

What is your safety plan In the event of an early/ Unplanned discharge from IFRP?

_____
_____
_____
_____

Where will you go?

_____
_____
_____
_____
_____

CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION

I, _____ give permission to Simon House Recovery/ Alcove Recovery Centre to contact:

_____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

Alcove
Addiction Recovery for Women

CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION

I, _____ give permission to Alcove Addiction Recovery for Women to contact

TO/FROM	Organization: ☐ Simon House Recovery Centre

WHAT INFORMATION	**To release verbally or in writing:** Please check the following information to be released ☐ Assessment ☐ Attendance ☐ Discharge Summary ☐ Treatment Plan ☐ Other (Please Specify) ☐ Participation ☐ Program Dates	**To collect verbally or in writing:** Please check the following information to be collected ☐ Assessment ☐ Attendance ☐ Relevant History ☐ Participation ☐ Other (Please Specify) ☐ Discharge Summary ☐ Reason for Referral ☐ Service Monitoring

CONSENT	I understand that provision of treatment services is not dependent upon my decision to release information and that I may cancel this consent at any time. I also understand that some action may have been taken prior to cancellation. **Client Signature:** _____ **Witness:** _____ **Date signed: _____ / _____ / _____** **Year Month Day** **Permission will expire on:** **_____ / _____ / _____** **Year Month Day**	*CANCEL*	I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation. **Client Signature:** _____ **Witness:** _____ **Date signed: _____ / _____ / _____** **Year Month Day**

SIMON HOUSE
RECOVERY CENTRE
empowering men to recover for life

CONSENT FOR RELEASE AND COLLECTION OF CONFIDENTIAL INFORMATION

I, _____ give permission to Simon House Recovery Centre to contact

TO/FROM	
	Organization: ☐ Alcove Recovery Centre for Women

WHAT INFORMATION	**To release verbally or in writing:**	**To collect verbally or in writing:**
	Please check the following information to be released	Please check the following information to be collected
	☐ Assessment ☐ Attendance ☐ Discharge Summary ☐ Treatment Plan ☐ Other (Please Specify) ☐ Participation ☐ Program Dates	☐ Assessment ☐ Attendance ☐ Relevant History ☐ Participation ☐ Other (Please Specify) ☐ Discharge Summary ☐ Reason for Referral ☐ Service Monitoring

CONSENT		CANCEL	
	I understand that provision of treatment services is not dependent upon my decision to release information and that I may cancel this consent at any time. I also understand that some action may have been taken prior to cancellation. **Client Signature:** _____ **Witness:** _____ **Date signed:** _____ / _____ / _____ **Year Month Day** **Permission will expire on:** _____ / _____ / _____ **Year Month Day**		I, _____, cancel this permission. I understand that some action may have been taken prior to this cancellation. **Client Signature:** _____ **Witness:** _____ **Date signed:** _____ / _____ / _____ **Year Month Day**

Please email or Fax completed forms to:
kgladue@simonhouse.com Fax 403 247 2104 Attention; Associate Director Indigenous Relations