KARIS SUPPORT SOCIETY
550 Rowcliffe Ave.
Kelowna, BC V1Y 5Y9
applications@karis-society.org
karis-society.org
250.860.9507 (TEL)
250.860.9517 (FAX)

APPLICATION FORM

Be sure you have filled out all required fields. Incomplete referrals will not be considered. After the referral has been sent, potential participant is required to call in weekly in order to remain on the wait list. The completed application package will be reviewed by the screening committee to assess eligibility into the program.

REFERRAL INFORMATION

Date: _____

Referring Agent: _____ Email: _____

Agency Name: _____ Address: _____

Agency Phone: _____ Agency Fax: _____

PARTICIPANT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____

Mobile: _____ Home Phone: _____

Email: _____

Care Card #: _____ DOB: _____ SIN: _____

Marital Status: _____ Ethnicity: _____

What program are you applying for? ☐ SINGLE LADIES

☐ PARENTING PROGRAM

If applying for the Parenting Program, is applicant currently pregnant? ☐ YES ☐ NO

Due date: _____

Is the child in custody now? ☐ YES ☐ NO

Does the applicant have MCFD involvement? ☐ YES ☐ NO

If YES, who is applicant's social worker? _____ Phone Number: _____

In what city does applicant have an open ministry file? _____

Number of children: _____ Number of dependent children: _____

CHILD'S NAME	AGE

Where do children reside? _____

Does applicant have children in day care? ☐ YES ☐ NO

If NOT, has applicant applied to different child care facilities? ☐ YES ☐ NO

** Karis's Parenting Program can only facilitate children up to the age of two-and-a-half years old.*

EMERGENCY CONTACT INFO

Name: _____ Address: _____

Phone: _____ Alternative Phone: _____

Relationship: _____

COMMUNITY SUPPORTS

Family Physician: _____ Telephone: _____

Psychiatrist: _____ Telephone: _____

Dentist: _____ Telephone: _____

Paediatrician: _____ Telephone: _____

Alcohol & Drug Counsellor: _____ Telephone: _____

Mental Health Worker: _____ Telephone: _____

Other Professional Community Supports: _____

Medical Conditions *(Diabetes, celiac, epilepsy, lactose intolerant):* _____

_____

MEDICATION	DOSAGE	CONDITION(S) BEING TREATED

Is applicant in the methadone or suboxone program? ☐ YES ☐ NO

If YES, is applicant allowed carries? ☐ YES ☐ NO

What is the dosage? _____

BEHAVIORS		HOW OFTEN	LAST TIME	MANAGEMENT
Seizures	☐ YES ☐ NO			
Suicide attempts	☐ YES ☐ NO			
Self-inflicted violence (cutting)	☐ YES ☐ NO			
Hospitalization	☐ YES ☐ NO			

Does applicant have pending criminal charges? ☐ YES ☐ NO

Has applicant been incarcerated previously? ☐ YES ☐ NO

If YES, what were the charges? _____

Up and coming court dates? _____

Probation? ☐ YES ☐ NO

Probation Requirements? ☐ WEEKLY CHECK-IN ☐ MONTHLY ☐ OTHER _____

Name of probation officer: _____ Phone number: _____

What are the convictions / charges? _____

Has applicant accessed the following low income housing?

- ☐ NOW CANADA
- ☐ BC HOUSING
- ☐ CMHA SUTHERLAND
- ☐ JOHN HOWARD

If YES, what was the date applicant resided there and the reason applicant left? _____

_____

EDUCATION

GRADE COMPLETED: _____

- ☐ HIGH SCHOOL
- ☐ TRADE JOBS
- ☐ COLLEGE DIPLOMA
- ☐ UNIVERSITY

Does the applicant have any special needs (Eg. literacy, disability, allergies)? Please describe:

_____

_____

INCOME

- ☐ INCOME ASSISTANCE _____
- ☐ DISABILITY _____
- ☐ PERSON OF MULTIPLE BARRIERS _____
- ☐ CHILD TAX CREDIT _____
- ☐ OTHER _____

Additional notes: _____

_____

MEDICAL

Does applicant have any of the listed psychiatric diagnoses?

- ☐ DEPRESSIVE DISORDER
- ☐ BI-POLAR
- ☐ PERSONALITY DISORDER *(please specify)* _____
- ☐ SCHIZOPHRENIA OR OTHER PSYCHOTIC DISORDER _____
- ☐ ANXIETY DISORDER
- ☐ EATING DISORDER

Is applicant stable? ☐ YES ☐ NO If YES, for how long? _____

What are the impacts on daily life? Please explain: _____

Has applicant been hospitalized within the past 30 days? ☐ YES ☐ NO

Last TB test? _____

Communicable diseases? ☐ YES ☐ NO

- ☐ HIV
- ☐ HEP C, B or A
- ☐ STD
- ☐ MRSA
- ☐ MOBILITY ISSUES
- ☐ COGNITIVE IMPAIRMENT
- ☐ HEAD INJURIES *(due to assault, concussion, unconscious)*
- ☐ FASD

For checked boxes, please explain current treatment: _____

Does applicant have a history of domestic violence? ☐ YES ☐ NO

If YES, has applicant received services through the Elizabeth Fry Society? ☐ YES ☐ NO

Is applicant currently in danger? ☐ YES ☐ NO

Is there a no-contact order in place? ☐ YES ☐ NO

Is applicant currently in a relationship? ☐ YES ☐ NO

How will that affect their participation in the program? _____

ALCOHOL & DRUG USE SUMMARY

TYPE	AGE OF FIRST USE	HOW OFTEN USED (Daily / weekly / monthly)	AMOUNT / QUANTITY	DATE LAST USED (Month / day / year)
ALCOHOL BEER / WINE / HARD LIQUOR				
CANNABIS POT / HASH				
COCAINE CRACK / COKE				
HALLUCINOGEN ACID / MUSHROOMS / PCP / KETAMINE				
BARBITURATE PHENNIES / YELLOW JACKETS				
AMPHETAMINE CRYSTAL METH / ECSTASY / SPEED				
HEROIN CHINA WHITE / CRANK				
OPIATE MORPHINE / CODEINE / OPIUM				
INHALANT GLUE / HAIRSPRAY				
ILLICIT METHADOSE				
BENZODIAZEPINE SLEEPING PILLS / TRANQUILIZERS				
OVER THE COUNTER DRUGS COUGH SYRUP				
OTHER PRESCRIPTION DRUGS T3s / VALIUM				
TOBACCO				
OTHER				

IMPORTANT NOTE | ADMISSION CRITERIA:

Applicant must have 2 weeks (14 full days) clean from alcohol and drugs prior to admission to program. NO EXCEPTIONS. Applicants will be drug tested upon admission. If tested positive applicant will be declined acceptance into the program.

EXPERIENCE WITH	DATES	COMPLETE / INCOMPLETE
RESIDENTIAL TREATMENT		☐ COMPLETE ☐ INOMPLETE
SUPPORTIVE RECOVERY		☐ COMPLETE ☐ INOMPLETE
DETOX		☐ COMPLETE ☐ INOMPLETE

APPLICANT SELF-ASSESSMENT

What are your personal goals while at Karis? _____

_____

Are you willing to be involved in intensive counselling? ☐ YES ☐ NO

Do you believe that your addictions are a problem to your well being? ☐ YES ☐ NO

Do you desire and have a willingness to change? ☐ YES ☐ NO

Are you willing to adhere to Karis rules and regulations while in the program? ☐ YES ☐ NO

Are there any major problems in your life relating to drugs and alcohol in the following areas?

- ☐ PHYSICAL HEALTH
- ☐ HOUSING
- ☐ EMPLOYMENT
- ☐ LEGAL
- ☐ FAMILY
- ☐ LEISURE TIME
- ☐ MENTAL HEALTH
- ☐ FINANCIAL / DEBT

Explain: _____

_____

_____

Are you currently attending any of the following programs?

- ☐ ALCOHOLICS ANONYMOUS
- ☐ NARCOTICS ANONYMOUS
- ☐ 12 STEP PROGRAMS
- ☐ OTHER _____

Why have you chosen Karis? _____

_____

Are you aware that Karis is a faith-based organization? ☐ YES ☐ NO

Are you wanting a faith-based organization? Why or why not? _____

_____

Who will be your community supports while you are in the program? _____

_____

APPLICANT SNAP (STRENGTHS, NEEDS, ABILITIES, PREFERENCES)

What do you believe your strengths are (assets, resources)? _____

_____

Needs (liabilities / weaknesses): _____

Abilities (skills, capabilities, talents): _____

Preferences (things you feel will enhance participant experience while within Karis): _____

_____

In your own words, what do you feel are your present challenges and problems? _____

_____

Are you willing to go into treatment prior to coming in to Karis? ☐ YES ☐ NO

What are your expectations for Karis Support Society? _____

_____

Karis Support Society offers participants to stay up to 2 years in the building. If accepted, how long do you believe you would like to be in our program? _____

_____

Please send all completed applications via email or fax to:
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