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 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.

### ADMISSION CRITERIA

- Potential participants must have 2 weeks (14 full days) sobriety from alcohol and drugs prior to admission to the program.
- Potential participants will be drug tested upon admission. If tested positive applicant will be declined acceptance into the program.
- Participants must be stable for residence in a non-medical setting. Applicants that require medical withdrawal will be required to do so before entry.
- Karis's Parenting Program can only facilitate children up to the age of two-and-a-half years old.
- Participants must be willing to live in a community setting in a semi-structured recovery-centered live-in program.
- Participants must be capable of participating in programming. Active participation is an essential requirement of programming.

### REFERRAL INFORMATION

Date: \_\_\_\_\_

Referring Agent: \_\_\_\_\_

Email: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

Agency Phone: \_\_\_\_\_

Agency Fax: \_\_\_\_\_

What program are you applying for?

SINGLES PROGRAM

PARENTING PROGRAM

### PARTICIPANT INFORMATION

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Care Card #: \_\_\_\_\_ DOB: \_\_\_\_\_ SIN: \_\_\_\_\_

Marital Status: \_\_\_\_\_

## CULTURAL INFORMATION

We invite you to let us know if there are any cultural, spiritual or religious practices or ceremonies that will support your wellness while at Karis.

Ethnicity: \_\_\_\_\_

Indigenous Ancestry?  YES  NO

Does the applicant currently have status?  YES  NO

Band: \_\_\_\_\_

Specific care requested? \_\_\_\_\_

## DEPENDENT INFORMATION

Is applicant currently pregnant?  YES  NO

Number of children in applicant's care? \_\_\_\_\_

Children's current living situation? \_\_\_\_\_

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? \_\_\_\_\_

CHILD'S NAME	AGE

## EMERGENCY CONTACT INFO

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_

## COMMUNITY SUPPORTS

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Pediatrician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Alcohol & Drug Counsellor: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Mental Health Worker: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Other Professional Community Supports: \_\_\_\_\_  
How will these people support you in your recovery? \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

Medical Coverage: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Any current health concerns (e.g. Diabetes, high cholesterol)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does applicant have any dietary restrictions (e.g. lactose intolerant, celiac)?  YES  NO

If YES, please explain: \_\_\_\_\_

Allergies?  YES  NO

If YES, please explain: \_\_\_\_\_

History of hospitalization in the last 30 days?  YES  NO

MEDICATION	DOSAGE	REASON PRESCRIBED

Are you on current opiate maintenance therapy?  YES  NO

If YES, which therapy? \_\_\_\_\_

Are you allowed carries?  YES  NO

Who is your prescribing doctor? \_\_\_\_\_

Start date: \_\_\_\_\_ Dosage: \_\_\_\_\_

Duration of therapy? \_\_\_\_\_

History of seizures?  YES  NO

Are they withdrawal related?  YES  NO

If YES, please explain? \_\_\_\_\_

Head injury (due to assault, MVA etc.)?  YES  NO

If YES, please explain? \_\_\_\_\_

Diagnosis of FASD?  YES  NO

Does applicant experience any limits to mobility?  YES  NO

If YES, are they in need of additional support/accommodation? \_\_\_\_\_

History of diagnosis of cognitive disorder (e.g. impairment)?  YES  NO

If YES, are they in need of additional support/accommodation? \_\_\_\_\_

Last TB test? \_\_\_\_\_

History of communicable diseases?  YES  NO

- HIV
- HEP C, B or A
- STD
- MRSA

For checked boxes, please explain current treatment: \_\_\_\_\_

## MENTAL HEALTH HISTORY

Has applicant been diagnosed with any of the listed psychiatric disorders?

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

Is applicant currently in crisis?  YES  NO

What are the impacts on daily life? Please explain: \_\_\_\_\_

Does applicant currently have a wellness care plan?  YES  NO

## LEGAL HISTORY

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: \_\_\_\_\_

Charge description? \_\_\_\_\_

## SAFETY CONCERNS

History of suicidal ideation / attempts?  YES  NO

History of self-harm?  YES  NO

History of aggression / aggressive behaviors?  YES  NO

Does the applicant have a care plan in place?  YES  NO

Is applicant currently in a relationship?  YES  NO

Are they safe?  YES  NO

Are they sober?  YES  NO

How will that affect their participation in the program? \_\_\_\_\_

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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

## HOUSING / ACCOMMODATION

What is the applicant's current housing status? \_\_\_\_\_

Are there safe housing concerns?  YES  NO

Is housing stable?  YES  NO

Has applicant accessed the following affordable housing options?

NOW CANADA

BC HOUSING

CMHA SUTHERLAND

JOHN HOWARD

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

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Following completion of programming Is acquiring access to low-income housing part of applicant's goals? \_\_\_\_\_

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## EDUCATION

GRADE COMPLETED: \_\_\_\_\_

- HIGH SCHOOL
- TRADE JOBS
- COLLEGE DIPLOMA
- UNIVERSITY

Has the applicant experienced any barriers to learning? Are they in need of extra support?

Please describe: \_\_\_\_\_

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## INCOME

- INCOME ASSISTANCE \_\_\_\_\_
- DISABILITY \_\_\_\_\_
- PERSON OF MULTIPLE BARRIERS \_\_\_\_\_
- CHILD TAX CREDIT \_\_\_\_\_
- OTHER \_\_\_\_\_

Additional notes: \_\_\_\_\_

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Is securing employment part of your goals while at Karis?  YES  NO

## HISTORY OF SUBSTANCE MISUSE CONCERNS

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



## SUBSTANCE MISUSE TREATMENT HISTORY

EXPERIENCE WITH	NAME OF AGENCY	DATES	COMPLETE / INCOMPLETE
<b>RESIDENTIAL TREATMENT</b>			
<b>SUPPORTIVE RECOVERY</b>			
<b>DETOX</b>			

If incomplete, please explain: \_\_\_\_\_

## HISTORY OF OTHER ADDICTION CONCERNS

TYPE	DATE LAST ACTIVE	AGE AT FIRST EXPERIENCE
<b>PORNOGRAPHY ADDICTION</b>		
<b>SHOPPING ADDICTION</b>		
<b>SEXUAL ADDICTION</b>		
<b>GAMBLING ADDICTION</b>		
<b>OTHER</b> ( <i>hoarding, shoplifting etc.</i> )		
<b>DISORDERED EATING</b> <i>Binging</i> <i>Overeating</i> <i>Restricting</i>		

Are you currently attending any of the following programs?

- ALCOHOLICS ANONYMOUS (AA)
- NARCOTICS ANONYMOUS (NA)
- 12 STEPS PROGRAMS
- WELLBRIETY
- ANOREXIC AND BULEMIC ANONYMOUS (ABA)
- OTHER \_\_\_\_\_

## SELF-ASSESSMENT (STRENGTHS, NEEDS, ABILITIES, PREFERENCES)

Why is supported recovery the best fit for you? \_\_\_\_\_

\_\_\_\_\_

In your own words, what are your current challenges to maintaining a healthy lifestyle? \_\_\_\_\_

\_\_\_\_\_

Why have you chosen Karis? \_\_\_\_\_

\_\_\_\_\_

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

Are you open to engaging with our faith-based programming?  YES  NO

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? \_\_\_\_\_

\_\_\_\_\_

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 the Karis structure while in the program?  YES  NO

What is / are your motivation(s) for maintaining a recovery-based lifestyle? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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Needs (liabilities / weaknesses): \_\_\_\_\_

Abilities (skills, capabilities, talents): \_\_\_\_\_

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

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