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 read the information package. In addition, must fill 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 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.

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:_____

REFERRAL INFORMATION

Date:_____

Referring Agent: _____ Email:_____

Agency Name: _____ Address:_____

Agency Phone: _____ Agency Fax: _____

INCOME

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

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)
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				

Dependent Information

Is applicant currently pregnant? ☐ YES ☐ NO

If yes, when is the due date? _____

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

MEDICAL HISTORY

Allergies to Medication: _____

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 Y, please explain: _____

Allergies? ☐ YES ☐ NO

If Y, 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
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 Y, are they in need of additional support/accommodation? _____

History of diagnosis of cognitive disorder (e.g. impairment) ☐ YES ☐ NO
Is applicant 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

Has applicant been hospitalized for mental health concerns in the past 6 months? ☐ YES ☐ NO

Dates _____

Reasons _____

Covid-19 Vaccination Record

Immunization Status ☐ No dose ☐ 1 of 2 Dose ☐ 2 of 2 Doses

Immunization Type: _____

Date of first dose: _____

Date of second dose: _____

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? _____

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? _____

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? _____

_____

EMERGENCY CONTACT INFO

Name:_____ Address:_____

Phone:_____ Alternative Phone: _____

Relationship: _____

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? _____

_____

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/ACCOMODATION

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? _____

_____

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

_____

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?

_____

_____

SUBSTANCE MISUSE TREATMENT HISTORY

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

If incomplete, please explain: _____

HISTORY OF OTHER ADDICTION CONCERNS

TYPE	DATE LAST ACTIVE	AGE AT FIRST EXPERIENCE
PORNOGRAPHY ADDICTION		
SHOPPING ADDICTION		
SEXUAL ADDICTION		
GAMBLING ADDICTION		
OTHER (e.g. hoarding, shoplifting)		
DISORDERED EATING ☐ Binging ☐ Overeating ☐ Restricting		

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 into 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)? _____

_____

Needs (liabilities / weaknesses): _____

Abilities (skills, capabilities, talents): _____

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

_____

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