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

Steps to take:

1. **Read the information package.**
2. **Fill out all fields in order for your referral to be processed.**
3. **You will be contacted by Intake Staff within one week. Please ensure your contact information is accurate.**

Admission Criteria

- Willing to live in a community setting in a semi-structured recovery-centered residential program.
- Stability for residence in a non-medical setting.
- Expected to provide a substance-free urine screen upon arriving at Karis and before admission. Applicants that require medical withdrawal will be required to do so before entry.
- Active participation is an essential requirement of programming.

If applying for the Parenting Program

- The Program can facilitate children up to the age of two-and-a-half years old.

What program are you applying for? ☐ Non-Parenting at Karis Program
☐ Parenting at Karis Program

Participant Information

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

Preferred Name:_____ Preferred Pronoun: _____ Marital Status: _____

Is the applicant experiencing homelessness? ☐ Yes ☐ No

If No, then please provide:

Address: _____

City: _____ Postal Code: _____

Phone:_____ Email:_____

Care Card #_____ DOB:_____

Referral Information

Date: _____ Referring Agent:_____

Agency Name: _____

Email: _____

Address: _____

Agency Phone: _____ Agency Fax: _____

Income Source

- ☐ INCOME ASSISTANCE _____
- ☐ PERSONS WITH DISABILITIES (PWD) _____
- ☐ PERSON OF MULTIPLE BARRIERS _____
- ☐ CHILD TAX CREDIT _____
- ☐ OTHER _____

Current Treatment (If Relevant)

Name of center: _____

Address of center: _____

Phone number: _____

Client start date and discharge date: _____

Support person (if applicable): _____

Support person contact: _____

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				
FENTANYL				
OTHER				

Dependent Information

Is the applicant currently pregnant? YES ☐ NO ☐

If yes, when is the due date? _____

Does the applicant have MCFD involvement? YES ☐ NO ☐

If yes, name of social worker?_____Phone number: _____

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

Children's Information:
Please list all children in and out of your care.

CHILDS NAME	DATE OF BIRTH	IN APPLICANTS CARE. YES OR NO.

Medical History

Allergies to Medication: _____

Does the applicant have a BC medical/service card number? ☐ YES ☐ NO

Family Physician: _____ Telephone: _____

Any current health concerns (e.g. Diabetes, High cholesterol):

_____

_____

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

If Y, please explain: _____

In order for Karis to provide special dietary requirements, a doctor's note must be supplied.

Has Applicant been hospitalized in the last 30 days: ☐ YES ☐ NO

Reason:

_____

_____

MEDICATION	DOSAGE	REASON PRESCRIBED

Is the applicant on current harm reduction therapy? ☐ YES ☐ NO

Type _____

Who is the applicant's prescribing doctor? _____

Start date: _____ Dosage: _____

Has the applicant had a diagnosis of any of the following?

- ☐ ADHD
- ☐ FASD
- ☐ Borderline Personality Disorder (BPD)

- ☐ Autism Spectrum
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Eating Disorder
- ☐ Seizures
- ☐ Head Injuries
- ☐ Other _____

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

Has the applicant been hospitalized for mental health concerns in the past 6 months?

☐ YES ☐ NO

Dates: _____

Reasons: _____

Does the applicant experience any limits to mobility? ☐ YES ☐ NO

If yes, are they in need of additional supports/accommodations? _____

_____

Last TB test? _____

History of Communicable Diseases?

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

For checked boxes, please explain current treatment: _____

Legal History

Has the applicant been previously incarcerated? ☐ YES ☐ NO

If yes, what were the charges? _____

Does the applicant have a pending criminal charge? ☐ YES ☐ NO

If the applicant is currently incarcerated, where: _____

When is the expected release date? _____

Charge description: _____

Probation requirements:

_____

_____

Name of probation officer: _____

Phone number: _____

Has the applicant experienced Intimate Partner Violence? ☐ YES ☐ NO

Is the applicant currently in danger? ☐ YES ☐ NO

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

Community Supports

Family Physician*:* _____Telephone: _____

Dentist*:* _____Telephone: _____

Pediatrician*:* _____Telephone: _____

Alcohol & Drug Counsellor*:* _____Telephone: _____

Mental Health Worker*:* _____Telephone: _____

Life Skills Worker: _____ Telephone: _____

Other Professional Community Supports*:* _____

Is the applicant currently in a relationship? ☐ YES ☐ NO

Are they safe? ☐ YES ☐ NO

Are they sober? ☐ YES ☐ NO

How will that affect the applicant's participation in the program?

_____

_____

Cultural Information

How can Karis support the applicant in any cultural, spiritual, or religious practices or ceremonies while at Karis?

_____

_____

_____

Ethnicity: _____

Indigenous Ancestry? ☐ YES ☐ NO

Does the applicant currently have status? ☐ YES ☐ NO

Band: _____

Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____

Address: _____

Substance Misuse History of Treatment

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

If incomplete, please explain: _____

History of Other Misuse

TYPE	DATE LAST ACTIVE	AGE AT FIRST EXPERIENCE
PORNOGRAPHY		

SHOPPING		
SEXUAL		
GAMBLING		
OTHER (e.g. hoarding, shoplifting)		
DISORDERED EATING ☐ **Binging** ☐ **Overeating** ☐ **Restricting**		

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 sustainable lifestyle?

_____

Why have you chosen Karis? _____

_____

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

What are your expectations for Karis Support Society? _____

How long do you expect to be at Karis? _____

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?

_____

_____

_____

SUBMIT

Please send all completed applications

via email to: applications@karis-society.org

or fax to: 250.860.9517