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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				

OTHER				
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BENZODIAZEPINE SLEEPING PILLS / TRANQUILIZERS				
OVER THE COUNTER DRUGS COUGH SYRUP				
OTHER PRESCRIPTION DRUGS T3s / VALIUM				
TOBACCO				
FENTANYL				

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.

CHILD'S NAME	Birth Date	In applicant's care? yes or no

Medical History

Allergies to Medication: _____

Does the applicant have a BC medical/service card number? _____

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?

- ☐ FASD
- ☐ Borderline Personality Disorder (BPD)
- ☐ Autism Spectrum
- ☐ Schizophrenia
- ☐ B-iPolar 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 support/accommodation? _____

Last TB test? _____

History of Communicable Diseases?

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

For checked boxes, please explain current treatment: _____

Legal History

*Please note As Karis is a substance use recovery program, individuals looking primarily for housing support are not eligible. Therefor all sentencing must be completed to be eligible for the program. Any applicant charged with harm of a child will not be considered.

Has the applicant been previously incarcerated? ☐ YES ☐ NO

If YES, what were the charges? _____

Does the applicant have pending criminal charges? ☐ 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 mis-use history of treatment

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

If incomplete, please explain: _____

History of other mis-use

TYPE	DATE LAST ACTIVE	AGE AT FIRST EXPERIENCE
PORNOGRAPHY		
SHOPPING		
SEXUAL		
GAMBLING		
OTHER (e.g. hoarding, shoplifting)		
DISORDERED EATING <input type="checkbox"/> Binging <input type="checkbox"/> Overeating <input type="checkbox"/> 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 or fax to:
applications@karis-society.org
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