



Residential Recovery Program Application Form

Please complete all fields to the best of your ability.

PLEASE PRINT CAREFULLY

Application Date	Month:	Day:	Year:	Address:
Last Name		First Name		Middle Name(s)
DOB: YY ____ MM ____ DD ____	Birthplace	Hair color	Eye color	
Contact Information: (phone, fax, email)				
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Transgendered Male to Female <input type="checkbox"/> Male <input type="checkbox"/> Transgendered Female to Male				
LIFE Recovery Association is an English-speaking ministry with an English curriculum. Are you fluent in English? _____				
For funding purposes, do you have Aboriginal Status? _____				
S.I.N. (or other ID):				
Emergency Contact Name:		Location:	Phone Number:	
Living situation last night (night before program entry):				
<input type="checkbox"/> Emergency Shelter including hotel or motel paid for by social services <input type="checkbox"/> Hotel or motel (where? _____)				
<input type="checkbox"/> Transitional housing <input type="checkbox"/> Psychiatric Unit at Hospital <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Detox (where? _____)				
<input type="checkbox"/> Substance/recovery treatment facility (where? _____) <input type="checkbox"/> Jail, prison, correctional facility (where? _____)				
<input type="checkbox"/> Rental housing <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> No fixed address				
<input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Own home/parents' home				
<input type="checkbox"/> Place not meant for habitation (a vehicle, abandoned building, bus/train/airport, tent city or anywhere outside)				
Length of stay at "living situation last night":				
<input type="checkbox"/> One week or less <input type="checkbox"/> More than one week but less than a month <input type="checkbox"/> One to three months				
<input type="checkbox"/> more than three months but less than a year <input type="checkbox"/> One year or longer				
Extent of Homelessness if applicable:				
<input type="checkbox"/> First time <input type="checkbox"/> 1-2 times in the past <input type="checkbox"/> 3 times in the past three years <input type="checkbox"/> Chronic: 4 or more times in the past three years				
Reasons for current situation:				
<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Health/Safety <input type="checkbox"/> Mental Health <input type="checkbox"/> Learning Disability <input type="checkbox"/> Eviction				
<input type="checkbox"/> No Affordable Housing <input type="checkbox"/> Substance Misuse <input type="checkbox"/> Addiction resulting in loss of job or family <input type="checkbox"/> Substandard Housing				
<input type="checkbox"/> Release from Corrections Facility <input type="checkbox"/> Criminal Activity <input type="checkbox"/> Medical Condition <input type="checkbox"/> Underemployment/Low Income				
<input type="checkbox"/> Bedbugs/other infestations (if so, which and how long ago?)				

Domestic Violence Information:

Are you a victim of domestic violence? Yes No

If yes, what is your relationship to the abuser? _____

If yes, extent of domestic violence:

within the past three months three to six months ago six to twelve months ago more than a year ago

Sources of Income:

No Financial Resources Income Assistance Provincial Disability Benefits

Employment Insurance (EI) Canada Pension Plan (CPP/CPD) Private Disability Insurance Worker's Compensation (WCB)

Spousal/Family Support Employment (where? _____ and how much do you earn? _____)

TOTAL MONTHLY INCOME: \$ _____

Education:

No Schooling completed 9th Grade High School Diploma

Elementary to 4th Grade 10th Grade GED

5th or 6th Grade 11th Grade Post-Secondary School

7th or 8th Grade 12th Grade, (No Diploma)

Are you in school or working on a certificate or degree? No Yes If Yes, explain:

Children

Names:	Age:	If under 19, what is the child's current living situation?

Please provide any relevant details regarding children. MCFD file? Any contact with children?

Legal Status

Are you a Registered Sex Offender? YES NO

Have ever been charged or convicted of sexual offenses? YES NO

Are you on Probation? YES NO If YES, convicted of _____

Name of Probation/Parole Officer: _____ Contact number: _____

Are you aware of any outstanding warrants for your arrest? YES NO

If you answered YES to the above, what is the nature of the charges?

General Health Assessment

I would rate my overall health as Excellent Very Good Good Fair Poor
 Are you pregnant? Yes Due date: MMM ____ DD ____ YY ____ No

Substance Use History

	Drug of Choice?	Date Last Used	Typical Amount Used	Age at First Use
Alcohol				
Cannabis/ Marijuana (Medicinal)				
Crack Cocaine				
Cocaine				
Heroin				
Opioids				
Benzodiazepines				
Crystal Meth				
Amphetamines				
Hallucinogens				
Inhalants				
Methadone/Suboxone				
Fentanyl				

Process Addictions:

Gambling Pornography Internet gaming Cutting Sex Eating Exercise Other _____

Detox: When/where/how long _____

HEALTH CONCERNS

To assist us in processing your application, we ask that you complete the following sections as accurately as possible. Health concerns will not necessarily preclude you from admission into the program. We want to ensure that should you come into the program, we have the best supports in place to assist you.

Section 1: Medical Health:

Please indicate any medical issues you are currently dealing with. Check all that apply and write down any related medications or treatment you are taking.

- Arthritis medications: _____
- Diabetes medications: _____
- Pain (location: _____)
(location: _____)
(location: _____)
medications: _____
- Sleep issues medications: _____
- Brain injury medications: _____
- Heart condition medications: _____
- Stroke medications: _____
- Dietary restrictions please list: _____
- Chron's / Colitis medications: _____
- Mobility problems medications: _____
- Infectious disease – Hepatitis B/C, HIV/AIDS, etc. (which? _____) medications: _____
- Methadone (_____ mg) Suboxone (_____mg) Kadian (_____ mg)
- Other: _____ medications: _____

Section 2: Mental Health:

Please indicate any mental health issues you are currently dealing with. Check all that apply, and write down any related medications you are taking:

- Depression medications: _____
- Anxiety..... medications: _____
- Bi-polar..... medications: _____
- PTSD..... medications: _____
- ADHD medications: _____
- Schizophrenia medications: _____
- Hallucinations medications: _____
- Suicidal thoughts medications: _____
- Eating disorder medications: _____
- Personality Disorder medications: _____
- Other medications: _____

Section 3: Health Care Providers:

Please provide contact information for your current and recent medical and/or mental health care providers:

	<u>Name</u>	<u>Phone Number</u>	<u>Date of Last Visit</u>
Family Doctor	_____	_____	_____
Psychologist	_____	_____	_____
Counsellor	_____	_____	_____
Psychiatrist	_____	_____	_____
Pharmacist	_____	_____	_____
Social Worker	_____	_____	_____
Other	_____	_____	_____

Section 4: Disclosure of Medical, Mental Health and Legal Information:

I, _____, consent to the collection and disclosure of my personal information, including information about my medical and/or mental health and legal information for the purposes of determining my suitability for LIFE Recovery Association's Residential Recovery Program.

Individual or Agency who can be contacted	Who	Title	Contact Number

Treatment History and Goals.

If you have been in addiction treatment programs in the past, please complete the following:

Name of Agency	Dates Enrolled	Length of Program	Did you complete?	If not, why?

What are your goals for entering our addiction treatment program?

Please continue to next page

BECK DEPRESSION INVENTORY

This questionnaire provides a number of statements for you to consider. Read each one carefully and circle the answer that best describes you **TODAY** (0, 1, 2 or 3) for each grouping.

1.
 - 0 I do not feel sad.
 - 1 I feel sad
 - 2 I am sad all the time and I can't snap out of it.
 - 3 I am so sad and unhappy that I can't stand it.
2.
 - 0 I am not particularly discouraged about the future.
 - 1 I feel discouraged about the future.
 - 2 I feel I have nothing to look forward to.
 - 3 I feel the future is hopeless and that things cannot improve.
3.
 - 0 I do not feel like a failure. I feel I have failed more than the average person.
 - 1 As I look back on my life, all I can see is a lot of failures.
 - 2 I feel I am a complete failure as a person
4.
 - 0 I get as much satisfaction out of things as I used to.
 - 1 I don't enjoy things the way I used to.
 - 2 I don't get real satisfaction out of anything anymore.
 - 3 I am dissatisfied or bored with everything.
5.
 - 0 I don't feel particularly guilty
 - 1 I feel guilty a good part of the time.
 - 2 I feel quite guilty most of the time.
 - 3 I feel guilty all of the time.
6.
 - 0 I don't feel I am being punished.
 - 1 I feel I may be punished.
 - 2 I expect to be punished.
 - 3 I feel I am being punished.
7.
 - 0 I don't feel disappointed in myself.
 - 1 I am disappointed in myself.
 - 2 I am disgusted with myself.
 - 3 I hate myself.
8.
 - 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.
9.
 - 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.
10.
 - 0 I don't cry any more than usual.
 - 1 I cry more now than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.
11.
 - 0 I am no more irritated by things than I ever was.
 - 1 I am slightly more irritated now than usual.

12. 2 I am quite annoyed or irritated a good deal of the time.
 0 I have not lost interest in other people.
 1 I am less interested in other people than I used to be.
 2 I have lost most of my interest in other people.
 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
 1 I put off making decisions more than I used to.
 2 I have greater difficulty in making decisions more than I used to.
 3 I can't make decisions at all anymore.
14. 0 I don't feel that I look any worse than I used to.
 1 I am worried that I am looking old or unattractive.
 2 I feel there are permanent changes in my appearance that make me look unattractive.
 3 I believe that I look ugly.
15. 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
16. 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired from doing almost anything.
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
 1 I have lost more than five pounds.
 2 I have lost more than ten pounds.
 3 I have lost more than fifteen pounds.
20. 0 I am no more worried about my health than usual.
 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
 2 I am very worried about physical problems and it's hard to think of much else.
 3 I am so worried about my physical problems that I cannot think of anything else.
21. 0 I have not noticed any recent change in my interest in sex.
 1 I am less interested in sex than I used to be.
 2 I have almost no interest in sex.
 3 I have lost interest in sex completely.

Please continue to next page

SUBSTANCE MISUSE SCREENING TEST DAST – Drug Abuse Screening Test

The following questions refer to your drug use. Substance misuse refers to (1) the use of prescribed or 'over-the-counter' drugs more than the directions, and/or (2) any legal or illegal non-medical use of drugs. Consider the past 12 months and carefully read each statement. Then decide whether your answer is YES or No and check the appropriate space. Please be sure to answer each question.

1. Have you used drugs other than those required for medical reasons?
 yes no
2. Have you ever abused prescription drugs or alcohol?
 yes no
3. When you abuse do you use more than one drug at a time?
 yes no
4. Can you get through the week without using alcohol or drugs?
 yes no
5. Are you always able to stop using alcohol or drugs whenever you want to?
 yes no
6. Have you ever had "blackouts" or "flashbacks" as a result of using alcohol or drugs?
 yes no
7. Do you ever feel "bad," "guilty," or "ashamed" about the way you use alcohol or drugs?
 yes no
8. Does your spouse, boyfriend, girlfriend, or parent ever complain about your use of alcohol or drugs?
 yes no
9. Has alcohol or drug abuse created problems in one or more of your significant relationships?
 yes no
10. Have you lost friends because of your use of alcohol or drugs?
 yes no
11. Have you neglected an important relationship because of your alcohol or drug use?
 yes no
12. Has your alcohol or drug use ever gotten you in trouble at your employment?
 yes no
13. Have you ever lost a job because of alcohol or drug abuse?
 yes no
14. Have you ever gotten into a fight when under the influence of alcohol or a drug?
 yes no
15. Have you ever done anything illegal in order to obtain alcohol or drugs?
 yes no
16. Have you ever been arrested for possession of illegal drugs?
 yes no

17. Have you ever been arrested or had an automobile accident while under the influence of drugs or alcohol?
 yes no
18. Have you ever had medical problems (like memory loss, hepatitis, convulsions, bleeding, etc.) as a result of using drugs or alcohol?
 yes no
19. Have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs or alcohol?
 yes no
20. Have you ever sought help from anyone for a drug or alcohol problem?
 yes no
21. Have you ever been involved in a treatment program especially related to drugs or alcohol?
 yes no
22. Have you ever been dismissed from school, work or any other program because of your drug or alcohol abuse?
 yes no

Please continue to next page

Each statement below describes how a person might feel when starting therapy or approaching problems in their life. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel **right now**, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem," answer in terms of problems related to your drinking or drug use.

#	STATEMENTS	STRONGLY DISAGREE	DISAGREE	UNDECIDED	AGREE	STRONGLY AGREE
1	As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2	I think I might be ready for some self-improvement.	1	2	3	4	5
3	I am doing something about the problems that have been bothering me.	1	2	3	4	5
4	It might be worthwhile to work on my problems.	1	2	3	4	5
5	I'm not the one with the problem. It doesn't make much sense for me to consider changing.	1	2	3	4	5
6	It worries me that I might slip back on a problem I have already changed, so I'm looking for help.	1	2	3	4	5
7	I am finally doing some work on my problem.	1	2	3	4	5
8	I've been thinking that I might want to change something about myself.	1	2	3	4	5
9	I've been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10	At times, my problem is difficult, but I am working on it.	1	2	3	4	5
11	Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12	I'm hoping that I will be able to understand myself better.	1	2	3	4	5
13	I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14	I am really working hard to change.	1	2	3	4	5
15	I have a problem and I really think I should work on it.	1	2	3	4	5

16	I'm not following through with what I had already changed as well as I had hoped for, and I want to prevent a relapse of the problem.	1	2	3	4	5
17	Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18	I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19	I wish I had more ideas on how to solve my problem.	1	2	3	4	5
20	I have started working on my problem, but I would like help.	1	2	3	4	5
21	Maybe someone or something will be able to help me.	1	2	3	4	5
22	I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23	I may be part of the problem, but I really don't think I am.	1	2	3	4	5
24	I hope that someone will have some good advice for me.	1	2	3	4	5
25	Anyone can talk about change; I'm actually doing something about it.	1	2	3	4	5
26	All this talk about addiction and mental health is boring. Why can't people just forget their problems?	1	2	3	4	5
27	I'm struggling to prevent myself from having a relapse of my problem.	1	2	3	4	5
28	It's frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29	I have worries, but so does the next person. Why spend time thinking about my problems?	1	2	3	4	5
30	I am actively working on my problem.	1	2	3	4	5
31	I would rather cope with my faults than trying to change them.	1	2	3	4	5

Please continue to next page



We require confirmation that funding is in place prior to your arrival. Please indicate which payment plan you are subscribing to:

- (1) Ministry of Social Development and Social Innovation (MSDSI): If the applicant is on Income Assistance an application can be made to Ministry of Social Development and Social Innovation (See attached form: *Confirmation of Income*, MSDSI). Applicants should be aware that their rent will be covered while in treatment for up to three months (to a maximum of \$375 per month). **Please complete the form on the next page.**
- (2) Self pay: The applicant must provide a signed agreement below indicating that she is prepared to pay for the LIFE Recovery Association program. Payment is required upon arrival at LIFE Recovery Association. "Self-pay" applicants are also responsible for paying for all medications while in the program. LIFE Recovery Association will provide detailed invoices documenting prescription costs. The monthly amount for "self-pay" clients is \$3,000 per month (\$100 per day). **Payment must be provided upon arrival to LIFE Recovery Association.**
- (3) Extended Benefits through employer: LIFE Recovery requires a letter from the applicant's benefits provider verifying that funding is in place. **Please have the Benefits Administrator from the applicant's employer submit a letter by fax (604-855-6744) confirming that the program will be paid.**
- (4) Employment Insurance (EI): The applicant may be eligible for Employment Insurance if employed within the last year. **The applicant must provide documentation from Service Canada stating eligibility.**

Self-Pay Agreement

I, _____, have read and fully understand the conditions for admission to the LIFE Recovery program, as per the payment plan listed above. I agree to provide payment and any supporting documentation as required.

Signed this _____ day of _____, 20____

Signature: _____



CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

Service Provider Name LIFE Recovery Association	Fax Number 604-855-6744
Address Box 2652 Abbotsford, BC V2T 6R4	

Clients receiving assistance from the Ministry of Social Development and Poverty Reduction must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Poverty Reduction.

Client Full Name		
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Poverty Reduction to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature	Date Signed
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To be completed by ministry staff	
Does the client have an open file?	<input type="radio"/> Yes <input type="radio"/> No
Is the client receiving any other income?	<input type="radio"/> Yes <input type="radio"/> No
Source of income	_____
Amount of income	_____
Is the client pending any other income?	<input type="radio"/> Yes <input type="radio"/> No
Source of pending income	_____
Notes	
Ministry Staff Signature	Date Signed
*Be advised information is accurate as declared to the Ministry as of the date signed.	