Stepping Stones RECOVERY HOUSE FOR WOMEN

Contact Info:
Recovery House Phone: 250-897-0360 Fax: 250-897-0316
Email: steppingstoneshouse@telus.net
Mailing: c/o 1571 Burgess Rd, Courtenay BC, V9N 5R8
www.steppingstonesrecoveryhouse.ca

Hope House Resident Application and Family History

Please answer all questions to the best of your knowledge

Personal History

Name of Applicant:_____ Date:_____

Current Address:_____ City:_____

Province:_____ Postal Code:_____ Phone #:_____

E-mail:_____ Date of Birth:_____

Nationality/Nation/Band:_____

SIN#:_____ _____ _____ BCID#: _____ Drivers License#:_____

Status Card#: _____ Care#:_____

Single_____ Married_____ Common Law_____ Separated _____ Divorced _____

Name of Parents: _____ Phone#: _____

Name of Spouse or Partner: _____ Phone#: _____

Name of One Close Friend, Relative, or Sponsor: _____

Length of Time Known: _____ Relationship:_____ Phone#: _____

In Case of Emergency Contact: _____ Phone#: _____

Children: Yes_____ No_____ Name:_____ DOB_____

Name: _____ DOB _____ Name _____ DOB _____

What are your current child care/custody arrangements;_____

_____

Private care:_____ Court ordered:_____

What is your substance of misuse: _____ if more than one: _____

How long have you been using: _____

How long have you been clean: _____ Sober: _____

Have you been to Treatment before? Yes _____ No _____

Where have you been to treatment? _____

When was the last time and for how long? _____

Do you have any Outstanding or Current Court Obligations: Yes _____ No _____

Probation: Yes _____ No_____ Charges: _____

Medical History

Do you have Hepatitis C: Yes _____ No _____ HIV: Yes _____ No _____

Any other Diseases or Health Problems: _____

Liver: _____ Heart: _____ Breathing: _____ Circulation: _____

High Blood Pressure: _____ Diabetes:_____ Anxiety: _____

Depression: _____ Allergies including Environmental : _____

Seizure Disorder: _____Active Eating Disorder:_____ Other: _____

Do you have any history of disordered eating? □ Yes □ No

If yes, please define:
Binge Eating ____ Vomiting ____ Restricting ___ Laxatives ____ Excessive exercising _____

Other, please describe: _____

Is your disordered eating still active? □ Yes □ No When last active? _____

List all Medications that you are Taking: (New Medications Must Be Disclosed)

_____

_____

Income Source

Are you currently Employed: Yes _____ No _____

Are you on Employment Insurance: Yes _____ No _____

Are you on Income Assistance: Yes _____ No _____

Are you on Persons With Disabilities: Yes _____ No _____

Are you Private Pay: Yes _____ No _____

Personal Goal:

Please provide a detailed Recovery Plan including specific short and long term goals that you would like to accomplish while living at Stepping Stones Hope House. Please state how you will accomplish these goals:

_____

_____

_____

_____

I hereby acknowledge that I have read and understand the Residence Application Form

and the House Rules/Protocol attached to this Form.

Client Signature: _____ Date signed _____

Staff Signature: _____ Date signed _____

Date Reviewed: _____ Admitted Yes _____ No _____Date _____

Date of Admission: _____Signed_____

Date of Discharge: _____ Signed: _____

BRITISH COLUMBIA | Ministry of Social Development and Social Innovation

ADMITTANCE AND DISCHARGE

SR Number:

The personal information requested on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act*, section 26(c) and is subject to all of the provisions of that Act. The information will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*, to determine eligibility and to make payment for the type of assistance requested. For further information regarding the collection, use and/or disclosure of your personal information, please contact the Ministry of Social Development and Social Innovation office that you receive services from.

INDICATE FACILITY TYPE

- ☐ Residential Community Care Facility
- ☐ Residential Mental Health Facility
- ☐ Residential Substance Use Facility
- ☐ Assisted Living Community Care Facility
- ☐ Assisted Living Mental Health Facility
- ☒ Assisted Living Substance Use Facility, including Registered Supportive Recovery Home

FACILITY INFORMATION

FACILITY NAME	PHONE NUMBER	FAX NUMBER
Hope House SP 1-42294443588 (ALR)	(250) 897-0360	(250) 897-0316

ADDRESS	POSTAL CODE
1535 Burgess Rd, Coutenay	V9N 5R8

FACILITY MANAGER CONTACT INFORMATION: Theresa McNicol

CLIENT INFORMATION

LAST NAME	FIRST NAME	INITIALS

DATE OF BIRTH (YYYY MMM DD)	CASE NUMBER

SOCIAL INSURANCE #	MSP NUMBER	PHN NUMBER

DATE OF ADMITTANCE (YYYY MMM DD)	OR	DATE OF DISCHARGE (YYYY MMM DD)

IS THE CLIENT REQUESTING TRANSPORTATION TO AND/OR FROM AN A & D TREATMENT CENTRE?	IF "YES", WHAT KIND?
YES ☐ NO ☐	

IS THE CLIENT ELIGIBLE FOR COMFORTS FUNDS?	IS ASSISTANCE WITH SHELTER COSTS REQUIRED?	ESTIMATED LENGTH OF TIME THE SHELTER COST ASSISTANCE WILL BE REQUIRED?
YES ☐ NO ☐	YES ☐ NO ☐	

Fax to the Ministry of Social Development and Social Innovation at:

I, _____ hereby authorize the staff from the Ministry of Social Development and Social Innovation to obtain and release information from my file required to establish payment of user charges. This includes any income or assets received or pending, and any missing documents that might affect my eligibility.

CLIENT SIGNATURE	DATE SIGNED (YYYY MMM DD)

****** BOTTOM SECTION TO BE COMPLETED BY MINISTRY WORKER/ UPDATE CLIENT FILE /COPY OF THIS COMPLETED DOCUMENT IS TO BE PROFILED TO ICM AND FAXED TO THE FACILITY ******

The client is required to pay a monthly contribution to the facility in the amount of: **$**

If a monthly contribution applies, it will be paid from the client's: CPP ☐ EI ☐ CPPD ☐ Other ☐

IF OTHER, PLEASE INDICATE INCOME SOURCE:

NOTE: It is the facility's responsibility to collect from the client any other income and apply it as client contribution towards their user charges.

WORKER SIGNATURE	WORKER NAME (PLEASE PRINT)

WORKER'S COMMENTS

PROOF OF INCOME MUST BE ATTACHED TO THE USER CHARGES

Security Classification: MEDIUM SENSITIVITY

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CONSENT TO DISCLOSURE OF INFORMATION

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 collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* You have the right to revoke this consent at any time. Any questions regarding this form should be directed to your local Employment and Assistance office.

CLIENT NAME	
SR NUMBER (IF APPLICABLE)	CASE NUMBER (IF APPLICABLE)

I consent to the disclosure of any personal information currently held under the custody and control of the Ministry of Social Development and Social Innovation subject to the following limitations:

☐ 1. The following specific information only. (If more space is required, please attach an additional page)

☐ 2. All information relevant to the determination of eligibility for:

☐ Income Assistance ☐ Hardship Assistance

☐ Disability Assistance ☐ Supplements

This information may be disclosed to an agency and/or an individual:

AGENCY NAME		INDIVIDUAL NAME	
ADDRESS			
CITY / TOWN	POSTAL CODE	TELEPHONE NUMBER	FAX NUMBER
AGENCY NAME		INDIVIDUAL NAME	
ADDRESS			
CITY / TOWN	POSTAL CODE	TELEPHONE NUMBER	FAX NUMBER

This consent is effective on the date it is signed and will remain valid until I request that it be cancelled.

SIGNATURE OF PERSON GIVING CONSENT	DATE (YYYY MMM DD)
NOTE: If you are signing on behalf of the Ministry Client, you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Consent.	

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Payment Information

Please call during office hours Mon –Fri 8:30am to 3:00pm to get information on cost of programming.

☐ **Self Payment**:
I agree to pay Stepping Stones Recovery House for Women a daily per-diem.
Fees are payable upon admission by cash, certified cheque, money order,

☐ **Ministry of Social Development:**

Should my financial situation change while in residence at Stepping Stones Recovery House for Women, I agree to all Self Payment agreements
Funding must be prearranged

☐ **Employment Insurance:**

When did you apply_____

When does your claim end_____

Payment must be made before the 1st of each month of your stay

☐ **Mental Health and Addictions Services:**

Contact Name: _____ Phone: (___)_____

Date of fee subsidy application: _____

Billing reference #: _____ # of Days _____

Self Pay Refund Policy: I acknowledge that should I choose to leave Stepping Stones Recovery house or be asked to leave for non-compliance of rules before my 3 month completion date, I will not recieve any money back, but all unused per diam funds will be held in trust for 1 year should I decide to return and continue to work on my recovery, and that if I choose to not return within one year I will forfeit all such money.

I have read and understand the Stepping Stones Recovery House Refund Policy:

_____ _____
Signature Date

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To Whom it may Concern:

Thank you for your interest in applying to Stepping Stones House for Women/ Hope House. Below I have written a list of possible agencies who may be involved with individuals who are applying to our program. Please make sure Personal Physician is included

Ministry of Social Development Worker
Mental Health & Addiction Counsellor
* Personal Doctor
Corrections BC (probation officer, lawyer)
Psychologist/Counsellor
Family Services
Transition Houses
Shelters
Recovery Houses applicant has attended

Instructions:
A) Please complete the top portion with Applicants personal information.
B) Then list all agencies in column 1-5, with contact information (phone number & fax)
C) Also, sign and date the completed form
If you require more space please photocopy and submit all copies.

Thank You

Theresa McNicol
Executive Director
Stepping Stones House for Women Society

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CONSENT FOR RELEASE OF INFORMATION

PLEASE COMPLETE THE APPROPRIATE SECTION(S) AND SIGN THE BOTTOM OF THE FORM

Family Name	First Name	Date of Birth (yyyy/mm/dd)
Personal Health Number	Address	

I give my permission for the exchange of information relevant to my care between
Stepping Stones Recovery House for Women Team and the following person(s) and/or agencies:

Person/Agency Name	Phone and Fax Number	Additional Info
1.		
2.		
3.		
4.		
5.		

This consent will expire on _____ or as otherwise revoked by me.

_____ _____ _____
Client's Signature Staff Member Signature Date

YOUR PRIVACY

Your privacy is important and we work diligently to ensure your personal information is treated in a confidential manner in accordance with the Freedom of Information and Protection of Privacy Act (FOIPPA). We will only share necessary and relevant information as follows:

- For ongoing care and services (including involvement with your family physician, counsellors, social workers and any other members of your care team).
- To maintain contact with you and/or to assist us in continually improving the quality of our care and services.
- As prescribed or required by law (eg. court orders, subpoenas), including the FOIPPA.

The above has been reviewed with me and I understand this privacy information.

_____ _____ _____
Client's Signature Staff Member's Signature Date

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Pre-Admission Medical Status Questionnaire
To Be Completed By a Physician

Patient Information:

First Name: _____ Last Name: _____

Health Card #: _____ Date of Birth: _____

Province: _____ Patient Phone #: _____

Height: _____ Weight: _____

Date of last Chest X-ray or Mantoux test for Tuberculosis & results: _____

(A TB test result less than 12 months old is required to qualify for admission)

Drug/Food Allergies: _____

Medication:
Please check all categories representing types of prescription medication that are currently being used:

☐ Anti-depressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain medication

☐ Other (specify): _____

List the name and dosage of any medication the patient is currently taking and how long they have been taking each medication: _____

_____

Methadone:

Length on methadone program: _____ Current dose: _____ ml.

Length of time on current dose: _____

Prescribing methadone Doctor's name: _____

Phone number: (___) _____

Medical History:

Current health/dental symptoms/conditions/diagnosis: _____

_____

Has patient suffered seizures in the past year: ☐ Yes ☐ No

If yes, were these seizures withdrawal related: ☐ Yes ☐ No

If no, do they have a seizure disorder: ☐ Yes ☐ No

If yes, please describe: _____

_____

Mental Health:

Is the patient currently seeing a mental health worker or a psychiatrist? ☐ Yes ☐ No

Worker/Doctor: _____ Agency: _____

Phone: (___) _____

Currently Being Treated	Past Diagnosed/ Treated	
		Attention Deficit Disorder
		Anxiety Disorder
		Eating Disorder
		Obsessive-Compulsive Disorder
		Post Traumatic Stress Disorder
		Learning Disability
		Borderline Personality Disorder
		FAS/FAE
		Depression
		Bi Polar Disorder
		Dissociative Identity Disorder
		Chronic Pain
		Anti-Social Personality Disorder
		Other (specify):

Hospitalizations in the last year? ☐ Yes ☐ No

Dates/Reason: _____

Physician's Signature: _____

Physician's Name, Please Print: _____

License #: _____

Telephone #: _____

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Prescription Form
To Be Completed By a Physician

Dear Doctor:

In order to facilitate admission to our program as quickly as possible, we request that you provide written orders for all required medications. Please write out all orders for a duration your patient will be attending. If the patient may need any over the counter medications such as Tylenol or ibuprofen during his stay please also provide a written order for them.

Date: _____

Patient Name: _____

PHN # : _____

DOB: _____

Drug Allergies: _____

Medication	Instructions for Use	Days' Supply/ Quantity

***Discretionary Note: Please complete and include any approved over the counter medications and dose etc (Tylenol, Ibuprofen)**

Physician's Signature: _____

Physician's Name, Please Print: _____

License #: _____

Telephone Number: (___) _____

Fax Number : (___) _____

*All medications must comply with our medication administration policies. Clients cannot bring their own medications for staff to administer. Please contact our office at the above number if you have any questions.

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I, _____, do hereby authorize and give consent to an authorized representative of Stepping Stones/ Hope House Society to:

- **Confirm and access information regarding my legal history with *any* legal agencies, including the RCMP, Probation / Parole & Corrections associated with me, including my referral source; and**
- **to exchange information with my referral source regarding motivation and suitability, for the purpose of assessing my eligibility for the Stepping Stones Hope House program.**
- **to exchange information with its funding source to fulfill contract obligations,**

Additionally, if my application is approved, and only if Income Assistance is my present source of income, I authorize the exchange of information with the Ministry of Housing and Social Development for the purpose of confirming my current eligibility.

- ✓ **I agree to abstain from drug and alcohol use while involved with Stepping Stones/ Hope House Society, failure to do so will result in immediate termination.**
- ✓ **I understand that violence, aggressive behavior and weapons will not be tolerated**
- ✓ **I understand that non-authorized prescriptions may prevent my eligibility**
- ✓ **I agree to actively work on my personal recovery plan while in the program.**
- ✓ **I agree to submit to random urinalysis tests without notice**
- ✓ **I agree to participate in structured daily program support services, which include: counseling, life skills development, meetings, work experience, employment resources and recreational opportunities.**
- ✓ **I agree to develop supportive relationships within the program as this a large part of the therapeutic community program.**
- ✓ **I am physically, emotionally, and mentally capable of maintaining my own hygiene and self care.**
- ✓ **I understand that rooms are based on double occupancy**
- ✓ **Failure to adhere to these guidelines may result in immediate termination of my residency**
- ✓ **I confirm that all information submitted on this application form is accurate and correct.**

Applicant Signature:_____ Date: _____

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House Rules and Protocol

1. **When first coming into Hope House prior arrangements must be made for your program costs which includes room and board.**

2. **You will be required to have a urine test when you enter the program and you will be required to submit to a random urine test if requested to do so.**

3. **Potential Residents must have completed 3 months of treatment in order to be accepted into Hope House.**

4. **During an individual's stay on Monday to Friday residents must do Community Volunteer work, attend school, or have a part-time job.**

5. **Hope House is a Faith based, but not faith restrictive program, you will be requested to attend a Sunday Church service, and read from a morning devotional book.**

6. **Confirm outside appointments by filling out a request form and reviewing it with staff, make sure they do not conflict with other commitments.**

7. **All medications are to be blister packed and dispensed by Rexall, and only sealed vitamins are to be allowed.**

8. **All medications are to be kept in the office and supervised by staff only. When medications are taken they need to be signed for under each resident's name. There are to be no medications in the resident's rooms except for ventilators or puffers. There are some medications that you will not be allowed to take while participating in this program. (this will be discussed individually)**

9. **Personal care and breakfast are to be completed by 8:30 am. in time to begin daily devotionals. Clients are to be ready by 9:15 am in order to start daily program.**

10. **Residents are expected to be home for dinner and eat together, except when on approved outings. Dinner preparations should start early enough so that dinner can be ready by 5:30 pm.**

11. **There will be a posted list of chores, chores will be on a rotating schedule everyone is required to do the chores that are appointed to them each week. Everyone is responsible to keep the house clean, beds made, your area kept clean, floors, bathroom and vacuuming kept up daily.**

12. **Television is permitted after dinner until bedtime at 11:00 pm, when it does not conflict with any other program (except on weekends.) No cooking at night unless permission is given.**

13. **All staff, visitors and other residents must be treated with respect and dignity at all times. We will work together to make sure that there is no profane language or cursing.**

14. **There is a designated smoking area outside and no smoking whatsoever will be allowed in the house. Use outside ashtrays at all times. You will be required to supply your own tobacco.**

15. **When attending meetings and appointments it is important to respect the confidentiality of other members of the house. Hope House phone number is only to be given to family members and as a contact number for necessary business contacts such as personal physician and government agencies. The house address and phone number is not to be shared with any outside party.**

16. **Do not touch another resident's property without their permission.**

17. **There will be designated laundry days no laundry after 7:00 pm.**

18. **When residents are away from the Hope House they are not permitted to go to places where drugs are being used or where alcohol is being consumed. Residents should consult the House Manager if they are unsure about a particular situation.**

19. **The team will respond to specific situations on an individual basis. The team or house manager may find it necessary to make exceptions to the above protocol as individual situations may arise.**