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

Resident's Application Form And Family History:

Please answer all questions to the best of your knowledge

Name of Applicant:_____ Date:_____

Current Address:_____ City:_____

Province:_____ Postal Code:_____ Phone #:_____

E-mail:_____ Date of Birth:_____ Place:_____

Nationality/Nation/Band:_____

Religion, Faith or Belief:_____

_____

SIN#:_____ _____ _____ BCID#: _____BCD#: _____

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 ever been in a Treatment/Recovery/Support House: _____

When: _____ Where: _____

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

Probation: Yes _____ No_____ Charges: _____

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: _____Active Eating Disorder:_____

What would you like to address or overcome while at Stepping Stones House:

_____

_____

_____

_____

What are you willing to do to achieve a clean, sober, healthy and adjusted life: _____

_____

_____

Are you willing to be a part of a Faith Based Recovery Program: Yes _____ No _____

Explain: _____

Do you agree to submit to random urinalysis test upon entry as well as random urinalysis testing? Yes _____ No _____

Name of Family Doctor: _____ Phone#: _____

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

_____

_____

What Short Term Goals Would You Like To Achieve While Staying At Stepping Stones House: _____

_____

_____

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
STEPPING STONES RECOVERY HOUSE FOR WOMEN (ALR)	(250) 897-0360	(250) 897-0316

ADDRESS	POSTAL CODE
1571 BURGESS RD, COURTENAY	V9N 5R8

FACILITY MANAGER CONTACT INFORMATION

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

BRITISH COLUMBIA | Ministry of Social Development and Social Innovation

CONSENT TO DISCLOSURE OF INFORMATION

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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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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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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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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.

Stepping Stones RECOVERY HOUSE FOR WOMEN

What to Bring:

-Comfortable weather appropriate clothing sufficient for 7 days
-Sleepwear (pajamas, housecoat, and slippers)
-Fitness wear (t-shirts, track pants and runners)
-Toiletries (shampoo and conditioner)
-Blow dryer
-Hairbrush (hair ties and /or clips)
-Stamps, envelopes, pens and paper (Email and Internet access is not provided)
-Unopened bottle of Tylenol or Ibuprofen (if you foresee the need of nonprescription painkillers as Stepping Stones does not provide these over-the-counter medications)
-IPod/MP3 player or Walkman- (IPod touch is not permitted) they can be used when writing on step work, or gym workout
-Favorite pillow

What Not To Bring:

-Products containing alcohol (i.e. mouthwash, perfume, perfumed lotions, etc.)
-Clothing that depicts drugs, alcohol, sex or violence
-Clothing with offensive slogans
-Computers, laptops or electronics that have access to internet
- Mouthwash (unless non-alcohol)
-Pornographic material
-Opened medications or opened vitamins
-Rolling papers (tubes are allowed)
-Straight razors or razor blades
-Aerosol hairspray
-Hair dye
-Pictures/photo's that depict alcohol/drug usage
-Sheets/towels
-Clock radios

What You Need To Know:

- For reasons of safety and security client's personal belongings are subject to search by staff upon intake and at any time during the program
- Any opened food or tobacco products will be discarded at intake
- Prescription drugs and vitamins that are not blister packed will be discarded at intake unless unopened
- Please familiarize yourself with the house rules and protocol included in the intake package

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House Rules and Protocol

1. **When first coming into Stepping Stones House prior arrangements must be made for your program costs.**

2. **If you are asked to leave or you quit the program and then decide that you want to re-enter the program and work once again on your recovery, you must wait a 30 day period before you can re-apply to come back into Stepping Stones House.**

3. **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. You must have gone through detoxification before entering this program.**

4. **Stepping Stones 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.**

5. **Also as part of our program there is Group therapy, an in-house 12 step program Monday through Friday, Woman's NA meeting Wednesday at noon, crafts Friday morning, Thursday evening Women's AA meeting and Early Recovery Program (sponsored by Mental Health and Addictions) . Fitness time is mandatory two or three times per week (except when health conditions limit participation).**

6. **All residents no matter what stage they are at in the program must stay at Early Recovery Program at break-time. There is to be no leaving the premises.**

7. **Cell phones are to be handed in on arrival and will be kept in the office. You will be restricted from making any outside personal contact for the first two weeks. Residents can receive phone calls from family and friends after the two week restrictions period, at set times when they do not interrupt meals and programs. Phone calls are limited to 15 minutes providing that no other residents are waiting to use the phone. When others are waiting, the phone time limit will be reduced to 10 minutes.**

8. **Once you are off of your two-week restrictions from outside contact, the buddy system will be used from week 3 thru week 8. When a resident is on the buddy system, she may go on approved outings and must be accompanied by another resident, an approved sponsor/buddy or a Stepping Stones volunteer. The buddy/sponsor is to be in visual sight of the resident at all times. In week 9 through the 3rd month the resident will be on the honour system. When a resident is on the honour system, she may go on approved outings without a sponsor or buddy. Residents are still required to apply in advance for approval of outings. There will be a 9:00 pm curfew during the entire program.**

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

10. **All medications are to be blister packed and dispensed by Rexall, and only sealed vitamins are to be allowed. Upon dismissal from the program all remaining residence prescriptions will be returned to dispensing Pharmacy**

11. **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)**

12. **One of the Stepping Stones staff members will accompany clients to their doctor's appointments. The staff member will be present during any discussions involving medication reviews or specific changes in medications or any serious health issues.**

13. **Personal care and breakfast are to be completed by 8:30 am. in time to begin daily devotionals.**

14. **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.**

15. **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. Remember this is your home treat it as if you owned it.**

16. **Monday through Friday there are no scheduled programs between 3:00 pm and 5:00 pm with the exception of fitness days (fitness time is also between 3:00 pm and 5:00 pm two or three times per week and the day of the week may fluctuate). This unscheduled time is a good time to do step programs, study, write in a journal, have a quiet time, etc. Residents are not permitted to leave Stepping Stones during this free time without prior approval. 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.**

17. **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.**

18. **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.**

19. **When attending meetings and appointments it is important to respect the confidentiality of other members of the house. Stepping Stones 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.**

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

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

22. **Personal attire should adhere to the theme of modesty.**

23. **After you have been in the program for 3 calendar months, your recovery progress will be re-evaluated. You will meet with members of the Stepping Stones leadership team to discuss your progress to determine whether you are ready to leave the program or whether it is deemed beneficial to remain in the program for a longer period. If a resident continues in the program longer than 3 months they are to continue on the honor system and to continue with all aspects of the program unless a modified program has been agreed upon with the Stepping Stones management.**

24. **When residents are away from the Stepping Stones house on the buddy system or on the honor system 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.**

25. **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.**