Vancouver Island Therapeutic Community (VITC)

APPLICATION FORM

<table>
<tr><td colspan="4">NAME:</td><td>Application Date:</td></tr>
<tr><td>Birthdate:</td><td colspan="2">SIN#:</td><td colspan="2">Requested Date for Residency:</td></tr>
<tr><td colspan="4">Present Address:</td><td>Phone #:</td></tr>
<tr><td colspan="4">How long at this address?</td><td>MSP #:</td></tr>
<tr><td colspan="2">Marital Status:</td><td colspan="2">Employment Status:</td><td>Education:</td></tr>
<tr><td colspan="3">Emergency contact person:</td><td colspan="2">Contact Number:</td></tr>
<tr><td colspan="2">Relationship:</td><td colspan="3">Do you have picture I.D.? Yes _____ No _____</td></tr>
<tr><td colspan="4">REFERRAL SOURCE:</td><td>Contact:</td></tr>
<tr><td colspan="4">Location:</td><td>Phone:</td></tr>
<tr><td colspan="5">Do you identify as Indigenous? Yes _____ No _____</td></tr>
<tr><td colspan="5">****Please fill this out (with your client) and answer the following questions in all the sections</td></tr>
<tr><td colspan="5">PERSONAL GOALS: How would VITC help you in your recovery?</td></tr>
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Substances Used:	**Date of Last Use:**	**Amount/Frequency**	**Method**	**Number of Years Using:**
☐ Alcohol				
☐ Cannabis				
☐ Cocaine/Crack				
☐ Heroin				

☐ Morphine				
☐ Other Opiates (excluding Fentanyl)				
☐ Methamphetamine				
☐ Benzodiazepines				
☐ Fentanyl				
☐ Inhalants				
☐ Barbiturates				
☐ Other Prescription Drug				
☐ Other				

Have you ever used injection drugs? Yes ___ No ___	Have you ever shared a needle? Yes ___ No ___
Primary drug of choice:	Clean and Sober Date:

TREATMENT HISTORY: Please list all the treatment programs the you have attended, addictions assessments that you have participated in, recovery homes you has stayed at and any out-patient counseling or programs that you has received			
Name of Program & Location:	**Date started:**	**Length of Stay:**	**Completed (Y/N):**
DETOX:			
ADDICTION OUT-PATIENT COUNSELLING AND/OR DAY TREATMENT			

RESIDENTIAL TREATMENT:			
RECOVERY HOME/SUPPORTIVE RECOVERY:			
OTHER TREATMENT (please specify):			
MEDICATION USE: list all currently prescribed medications			
MEDICAL HISTORY: Physical Health: Good ___ Fair ___ Poor ___			
List any medical concerns including: special diets, allergies, open wounds or sores			
Have you been tested for HIV/AIDS and/or Hep-A, Hep-B, Hep-C?	Yes ___ No ___ Results:		
Date of last chest Xray or Mantoux test for TB: Date:			Result:
Note any current Mental Health concerns:			

Note any recent hospitalization for mental health concerns, suicidal ideation or suicide attempts, in the past 6 months - describe:
Other Special Needs (ie. literacy, etc):

EDUCATION / EMPLOYMENT:	
Are you currently employed? Yes __ No ___	If yes, part time or full time?
If yes, where?	
INCOME INFORMATION:	
What is your Source of Income?	
LEGAL HISTORY:	
Are you presently or soon to be on: O Probation O Parole O Bail	
Name of P.O:	Phone:
Do you have charges pending?	Court Date and Location:
Details of charge:	
Have you ever been convicted of a criminal charge? If yes, Please list all convictions and the year it was received(use additional page if needed)	
Have you ever been convicted of a sexual offence?	If yes, Date and Conviction:
	If yes, Dates:

Other court obligations: (ie. Family court, Family Maintenance, Public Trustee)
FAMILY AND SOCIAL SUPPORT (Peer Support, Marital Support, Family Support) Please list support that you have from outside sources:
PERSONAL GOALS Please provide a detailed Recovery Plan including specific goals that you would like to accomplish while living at the Vancouver Island Therapeutic Community housing. Please state in your plan how you will accomplish these goals.
IS THERE ANY OTHER IMPORTANT INFORMATION FOR US TO KNOW WHEN CONSIDERING THIS CLIENT'S APPLICATION TO THE VANCOUVER ISLAND THERAPEUTIC COMMUNITY PROGRAM?

I, ___________________________, do hereby authorize and give consent to an authorized representative of Connective Vancouver Island Therapeutic Community 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;
- to exchange information with its funding source to fulfill their contract obligations, and
- to exchange information with my referral source regarding motivation and suitability, for the purpose of assessing my eligibility for the Vancouver Island Therapeutic Community program.

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 the Vancouver Island Therapeutic Community, 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 understand this program is intended to provide long term treatment and will require a four month commitment to the program.
- ✓ 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: group therapy, 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 I am required to take my prescribed medication daily
- ✓ 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: _______________________

Payment Information:

- ☐ Self Payment:
  Fee Payable upon admission

- ☐ Employer/Other:
  Contact Name: ____
  Company Name/Agency: ________________________________
  Phone: ____
  Fax: ____
  Address: ____

- ☐ Mental Health and Addictions Services
  Please attach funding approval

- ☐ Ministry of Social Development and Poverty Reduction