Please read this page before filling out the application:

Please complete ***all*** the sections. Applications missing any data will be returned to be completed and may delay your admission to VITC. Please do not apply more than 90 days from the time you are requesting treatment.

If a section of the application does not apply to you, please enter N/A. Don't leave it blank.

Please ensure you have the latest application as downloaded from our website at https://connective.ca/services/vancouver-island-therapeutic-community/

Please use the following application checklist to ensure you're including all required information. Incomplete applications will not be accepted.

☐ Participant information
☐ Early Exit plan – Filled out with referral agent
☐ Participation Agreement is signed by Applicant
☐ A Voluntary Consent to Release Information Form for individuals that applicant would like the Connective Support Society VITC Staff to share information with (signed by referral source)
☐ VITC Expectations and Goals
☐ House Information and Rules (on VITC website)
☐ List of Medications
☐ Source of income
☐ Ministry of Social Development & Social Innovation Funding Verification Form

Upon receiving the completed package, your application will be reviewed by the VITC Treatment Team to determine your eligibility to enter the program. An interview will be conducted with the applicant to determine suitability. Waitlist applicants are required to provide updated information for their application if requested by VITC staff.

VITC Application Form

Application Date (yyyy/mm/dd):	**Requested Date for Residency (a date is mandatory):**
Last Name:	**First Name:**
Birthdate (yyyy/mm/dd):	**SIN #:**
Current Address (Street, Apt., City): **I don't have an address because:** ○ **I'm unhoused** ○ **I'm Incarcerated** ○ **Other (specify):**	
Applicant Email:	**Phone:**
Employment Status:	**Marital Status (Single, Married, Divorced):**
Emergency Contact Name:	**Relationship (Partner, Friend, Family, etc):**
Emergency Contact Phone and Email:	
Referred by (First name, last name, Agency):	
Referrers Email:	**Referral Phone:** **( )**

Check if the following statements are <u>true</u>:

- ○ I am not or will not be under house arrest
- ○ I am not required to wear an ankle monitor
- ○ I am mentally stable and can fully participate in classroom learning and groups
- ○ I am physically stable and can fully participate in chores and activities
- ○ I do not have any sexual offence convictions or pending charges
- ○ I do not have any arson convictions or pending charges
- ○ I identify as male and am over 19 years of age
- ○ I am not an active gang member
- ○ I do not need licensed care (i.e., do not need 24-hour professional health care supervision and care in a protective, supportive environment)

Check if you have:

- ○ Birth certificate
- ○ SIN Card
- ○ Status card
- ○ BC ID (Drivers Licence, BC ID, Health Card)
- ○ Bank account

Highest level of education completed:

- ○ Grade school (K-7)
- ○ Some high school
- ○ High school or GED
- ○ Trade school
- ○ Some college / university
- ○ College / University degree
- ○ None of the above
- ○ I don't know

Your vehicle:

- ○ I will not be bringing a vehicle
- ○ I have a valid driver's licence
- ○ The vehicle is in my name
- ○ I have insurance on the vehicle

Do you receive any government assistance?

- ○ Income Assistance
- ○ Employment Insurance
- ○ Persons with Disability Benefit (PWD)
- ○ Persons with Persistent Multiple Barriers Benefit (PPMB)
- ○ Pension
- ○ None of the above
- ○ I don't know
- ○ Other: _____

Legal Involvement:

Do you have any current or prior involvement in the legal system?

○Yes ○No

Are you currently Incarcerated? If so, where?

- ○ No
- ○ Ford Mountain (Xàws Schó:lha [house-Shhka-law]) Correctional Centre
- ○ Fraser Regional Correctional Centre
- ○ Kamloops Regional Correctional Centre
- ○ Nanaimo Correctional Centre
- ○ Guthrie Therapeutic Community, Nanaimo Correctional Centre
- ○ North Fraser Pretrial Centre
- ○ Okanagan Correctional Centre
- ○ Prince George Regional Correctional Centre
- ○ Surrey Pretrial Services Centre
- ○ Vancouver Island Regional Correctional Centre
- ○ Matsqui Institution
- ○ Kent Institution
- ○ Fraser Institution
- ○ Other (specify name/province): _____

Legal Status:

- ○ Sentenced, Serving time
- ○ Have PDD (Release) Date
- ○ Seeking Bail
- ○ On-Remand
- ○ On Own Recognizance
- ○ CSO
- ○ Probation
- ○ Day Parole
- ○ Full Parole

If you have a PDD/Release date what is that date (YYYY/MM/DD)? _____

Gender:

- ○ Man
- ○ Woman
- ○ Non-binary
- ○ Transgender
- ○ Two-spirit
- ○ Prefer not to answer
- ○ I don't know
- ○ Other: _____

Race (check all that apply):

- ○ First Nations
- ○ Metis
- ○ Inuit
- ○ Urban Indigenous
- ○ Other Indigenous
- ○ East Asian
- ○ Black
- ○ Hispanic/Latino
- ○ Middle Eastern
- ○ South Asian
- ○ White (Caucasian)
- ○ I don't know
- ○ Prefer not to answer

What is your employment status?

- ○ Employed
- ○ Unemployed
- ○ Contract worker
- ○ Self Employed
- ○ Odd jobs
- ○ I don't know

Children in care?

○ Yes ○ No ○ I don't know

Are you currently taking any of the following medications

- ○ Methylphenidate (Ritalin®, Concerta®, Biphentin®, Foquest®, Quillivant®)
- ○ Dextroamphetamine (Dexedrine®, Adderall®)
- ○ Lisdexamfetamine dimesylate (Vyvanse®)
- ○ Kadian, Codeine, Hydrocodone, Hydromorphone, Oxycodone, Dilauded, Darvocet, Darvon, Fentanyl
- ○ Lobazam (Onfi, Frisium, and Urbanol)
- ○ Clonazepam (Rivatril, Rivotril, Klonopin, Iktorivil, and Paxam)
- ○ Clorazepate (Tranxene and Tranxilium)
- ○ Alprazolam, Lorazepam, and Diazepam
- ○ Triazolam Halcion (triazolobenzodiazepine)
- ○ OAT (Methadone, Suboxone, Sublocade)
- ○ Other (specify): _____

My first drug of choice is: _____

My second drug of choice is: _____

Alcohol	Crystal meth
Cannabis	Amphetamines
Crack cocaine	Club drugs (MDMA, Ecstacy, etc.)
Cocaine	Hallucinogens (LSD, Psilocybin)
Heroin	Inhalants
Fentanyl	Over the counter
Other opiates	Benzodiazepine

Drug History:

Substance:	Last use:	Amount/Frequency (Daily/Weekly/Monthly/Binge):	Method (Snort/Smoke/IV):	# years used:
Alcohol				
Cannabis				
Fentanyl				
Heroin				
Other Opiates				
Crystal Meth				
Amphetamines				
Cocaine				
Crack Cocaine				
MDMA/Ecstasy				
Hallucinogens				
Ketamine				
GHB				
Inhalants				
Prescription Meds				
Benzodiazepines				
Steroids				
Other:				

Have you ever injected drugs by needle (IV)?	**Have you ever shared a needle?**
○ Yes ○ No	○ Yes ○ No

Have you tested positive for any of the following:

○ HIV ○ HEP C ○ MRSA ○ I haven't been tested

If yes, when? _____ Result: _____

Do you struggle with any of the following process addictions?

○ Gambling	○ Video games
○ Shopping	○ Sex
○ Eating	○ Work
○ Internet/social media	○ Exercise
○ Pornography	○ No

Safety Concerns:

Have you experienced suicidal thoughts in recent history? ○ Yes ○ No

Have you attempted suicide in recent history? ○ Yes ○ No

If yes, when and how many times? _____

Have you experienced an overdose(s) in recent history? ○ Yes ○ No

If yes, when and how many? _____

Do you struggle with Aggression, Anger, or Violence? ○ Yes ○ No

If yes, please specify: _____

Treatment History:

Program Name and Location:	Year	How long?	Complete? Y/N
Detox:			

Addiction Out-Patient Counseling and/or Day Treatment:			
Residential Treatment:			
Recovery Home or Supportive Living:			
Other Treatment (please specify):			
Health:			
Current Medications/Prescriptions:			

Current state of physical health: ○ Excellent ○ Good ○ Fair ○ Poor
Current Medical Conditions (Diabetes, Heart Disease, Cancer, COPD, etc):
Current Mental Health Conditions: ○ Anxiety ○ Depression ○ ADHD ○ PTSD ○ Schizophrenia ○ Suicidal thoughts/plans ○ Psychosis ○ Self-Harm ○ Personality Disorder (specify _____) ○ Other(specify_____)
Mental health history:
VITC Goals and Needs:
What is your motivation for accessing supportive recovery at VITC?
What are your recovery goals that you wish to accomplish during your time at VITC?

What do you think you will find most challenging about participating?
What are your barriers to maintaining recovery?

Early Exit Transition Plan

Should you decide to leave the program before completion or are discharged, the following plan is in place.

Client Name:	**Signature:**
Emergency Contact Name: Phone: Email:	**Relationship:**
Community Contact/Support Name: Phone: Email:	**Relationship:**
Discharge Plan for Weekday	**Discharge Plan for Weekend**
Destination Contact Name/Relationship	Destination Contact Name/Relationship
Destination Address	Destination Address
Do you have arranged transportation to/from VITC program? Yes ☐ No ☐	Do you have arranged transportation to/from VITC program? Yes ☐ No ☐
Mode of Transportation	Mode of Transportation
If no, who will transport?	If no, who will transport?

RELEASE OF INFORMATION

I, _____, authorize staff at Connective Support Services to collect and release my personal information to the following:

Collect	Release	a) Organization/Individual and b) the Reason

This consent to release or obtain personal information from the individuals or organizations listed above takes effect on (todays date) _____, and will expire either:

a) when I am no longer a client of Connective Support Services, or

b) annually on _____ (date a year from now), or

c) I may withdraw my consent at any time prior to the expiry date by writing it out and giving it to VITC staff.

Name of Client: _____

Signature: _____

Witnessed by: _____

Signature: _____

PRE-ADMISSION MEDICAL EVALUATION / INFORMATION

A Physician must complete the Pre-Admission Medical Evaluation forms.

Does this person require supervised medical withdrawal management services? ☐ Yes ☐ No

If yes, is medically supervised withdrawal management scheduled? ☐ Yes ☐ No

If yes, what date is withdrawal management expected to be completed?

Does the person have mobility challenges? ☐ Yes ☐ No

If yes, please indicate: Does the person have vision or hearing impairments? ☐ Yes ☐ No

If yes, please describe:

Does this person require assistance with physical hygiene care? ☐ Yes ☐ No

If yes, please describe:

Does the person have chronic pain? ☐ Yes ☐ No

If yes, please describe:

Do you have a history of:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Heart Attack			Sickle Cell Disease			Diabetes		
Congestive Heart Failure			Asthma			High Blood Pressure		
Heart Murmur			Tuberculosis			Kidney Problems		
Immunizations			Sleep Apnea or COPD			Urinary Problems		
Stroke			Jaundice			AIDS/HIV		
Pacemaker			Hepatitis			Heartburn/Acid Reflux		
Artificial Heart Valve			Liver Disease			Thyroid Disease		
Congenital Heart Disease			Bruising Easily			Epilepsy or Seizures		
Swollen Ankles			Psychiatric Care			Concussion		
Rheumatic or Scarlet Fever			Anxiety Disorders			Cancer		
Fainting or Dizziness			Depression			Radiation or Chemo		
Anemia			Artificial Joint			Alcohol Use		
Blood Clots			Neuromuscular Disorder			Recreational Drug Use		
Hemophilia			Arthritis			Cortisone/Steroid Use		
Active Psychosis			Suicidal ideation			Self Harm		

Doctor/Nurse Information

Doctor/Nurse Practitioner Name:	**Signature:**
Date of evaluation (dd/mm/year):	
Mailing address:	
Phone number:	Fax:

Patient release of confidentiality

I hearby authorize the above name physician and nurse practitioner to release to The Vancouver Island Therapeutic Community staff information which is required to assesmy suitability for acceptance into VITC.

Patient's Name:	**Date:**
Signature:	

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	BIRTH DATE

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.

2630 Labieux Rd., Nanaimo, BC V9T 3R6 Ph:250-758-5611 F250-758-2253 Connective.ca