INTAKE PROCESS

1. Complete application for each adult applicant.
2. Fax or e-mail completed application(s) to BLCS Intake Worker. Include all supporting documents.
3. BLCS will review application(s) for suitability.
4. BLCS will inform referral worker if application is approved/not approved.
5. BLCS will send acceptance letter with program dates to referral worker.

Adult Application to BLCS Family Counselling Program

To be completed by Applicant and Referring Worker, one per adult (18 and older)

GENERAL INFORMATION

DATE OF APPLICATION:		
Last Name:	First Name:	
Date of Birth (YY/MM/DD):	Home/Mobile Phone:	Work Phone:
Email:		
Mailing address:		
Aboriginal Ancestry: ❑ Yes ❑ No	Band Name: Band Number:	❑ On Reserve ❑ Off Reserve
OHIP #:		
Emergency Contact:	Phone:	
Relationship to Applicant:		

FAMILY RELATIONSHIPS

Marital Status: ❑ Married ❑ Common-Law ❑ Single ❑ Widow/widower
❑ Separated ❑ Co-Parenting ❑ Divorced

Child/Dependent First and Last Name	Age	M or F (Gender)	Relationship to Applicant	Attending with Applicant?
1.				❑ Yes ❑ No
2.				❑ Yes ❑ No
3.				❑ Yes ❑ No
4.				❑ Yes ❑ No
5.				❑ Yes ❑ No
6.				❑ Yes ❑ No

Are any children in care?	If Yes, please describe.	Attach document(s):
❑ Yes ❑ No		❑ Service Plan ❑ N/A ❑ Safety Plan ❑ N/A

CONSENT: I give consent for my Child and Family service worker to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials)

Contact Person: ______________________ Phone Number: ___________________________

Is the intention of attending treatment to have children returned to Applicant at the end of the Family Program? ❑ Yes ❑ No ❑ N/A

Please list any significant information with respect to your children. (Example: long-term illness, childhood, trauma, if a child has died.)

Family Supports:

Family Strengths:

Are there any physical challenges that require special attention? ❑ Yes ❑ No

If "Yes", please explain.

Will you require assistance with reading or writing English? ❑ Yes ❑ No

Will you require an interpreter? ❑ Yes ❑ No

List any known allergies

Check known medical conditions:

❑ Asthma ❑ Diabetes ❑ FASD ❑ Epilepsy ❑ Seizures

❑ DT's ❑ Pregnant ❑ Other: ______________________

List medical conditions:	Prescribed Medication and Dosage:
• ______________________	• ______________________
• ______________________	• ______________________
• ______________________	• ______________________
• ______________________	• ______________________
• ______________________	• ______________________
• ______________________	• ______________________

Have you ever contracted any communicable diseases? ❑ Yes ❑ No

E.g., TB, HIV/AIDS, Hepatitis C., bed bugs, lice, etc.

If "Yes", when?

How was it dealt with?

Is it an issue now? ❑ Yes ❑ No

All communicable diseases must be in remission and properly medicated.

6. Medical Condition of Children: (Use lines for names.)

❑ ADD ________ ❑ ADHD ________ ❑ Asthma ________ ❑ Epilepsy ________

❑ FASD ________ ❑ Diabetes ________ ❑ Seizures ________ ❑ Allergies ________

❑ Are any on medication?

EMPLOYMENT

Job:

Please select all that apply:

❑ Full time ❑ Part time ❑ Seasonal ❑ Other ______________

EDUCATION

Check all that apply:

❑ Elementary (Grades 1-8)
❑ High School
❑ High School Diploma
❑ Certificate: ______________
❑ College
❑ University
❑ Vocational: ______________________
❑ Other: ______________________

MENTAL HEALTH

Are you currently experiencing:

. Anxiety ❑ Yes ❑ No

Depression ❑ Yes ❑ No

Suicidal thoughts ❑ Yes ❑ No Have you attempted? ❑ Yes ❑ No Date: ____________

Have you ever been diagnosed with a mental illness? ❑ Yes ❑ No If "Yes", explain:

Are you concerned about violence in your life? ❑ Yes ❑ No If "Yes", explain:

List current mental health conditions:

- ________________________________
- ________________________________
- ________________________________

Prescribed Medication and Dosage:

- ________________________________
- ________________________________
- ________________________________

Beaver Lake
COUNSELLING

REASON FOR REFERRAL

Why are you seeking counselling at this time?
What is the main concern (issue)?
How long has this been a problem?
What do you expect from the counselling process?

TREATMENT HISTORY

Have you received counselling in the past six months? ❑ Yes ❑ No If "Yes", please explain.
Are you presently using mood-altering substances? ❑ Yes ❑ No E.g., alcohol, street drugs, prescription drugs (not prescribed by your doctor) If "Yes", please explain.
Have you been hospitalized because of substance misuse? ❑ Yes ❑ No If "Yes", please list date(s)

Beaver Lake
COUNSELLING

Are you in a addiction treatment program? ❑ Yes ❑ No

❑ Suboxone ❑ Methadone ❑ Other ____________

Current dosage per day: ______________________

CONSENT: I give consent for my treatment program supervisor to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials)

Contact Person: ____________________ Phone Number: _________________________

Have you participated in a community-based	Date	Program Completed
• substance abuse program ❑ Yes ❑ No Program Name ______________________________		❑ Yes ❑ No
• mental health program ❑ Yes ❑ No Program Name: _____________________________		❑ Yes ❑ No
• healing program ❑ Yes ❑ No Program Name: _____________________________		❑ Yes ❑ No
Have you participated in a residential treatment program? ❑ Yes ❑ No Program Name: ______________________________		Program Completed ❑ Yes ❑ No

LEGAL STATUS

Are any current legal orders or probation in place?	❑ Yes ❑ No
Is receiving counselling a condition of probation?	❑ Yes ❑ No
Are there any pending charges or court dates in effect?	❑ Yes ❑ No
CONSENT: I give consent for my probation officer to release the above information to Beaver Lake Counselling Services. ❑ ______ (Initials) Probation Officer: ____________________ Phone Number: _________________________	

PREFERRED FAMILY PROGRAM DATE

See Family Counselling Program at beaverlakecamp.org for program dates
First choice:
Second choice:

INFORMED CONSENT

I, (Applicant's Name, PLEASE PRINT) ______________________________, consent to attend BLCS and have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points:

____1. I consent to BLCS contacting referral agencies listed in this application to obtain clarification on information included in this application.

____2. I understand BLCS will notify my referral worker by letter to confirm my acceptance to treatment.

____3. While in treatment, I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility and referrer will be notified.

____4. I understand it is my responsibility to be free from and have taken care of all outside business that would take my attention away from the treatment program.

Please do not schedule any major medical treatments during the program.

____5. I understand if I am discharged early or voluntarily leave treatment, I am responsible for my travel.

____6. I understand that abusing substances while in treatment may result in my immediate dismissal from the program, with recommendations to a different treatment program.

____7. I understand that BLCS staff engage in case conferencing for the benefit of treatment and healing.

____8. If accepted, I consent for BLCS to discuss my progress and clarify any details with my referrer, if applicable.

Consent to Release Confidential Information

I, (Applicant's Name, PLEASE PRINT) ______________________, hereby give permission for BLCS staff to contact the referral worker(s) listed below for the release of information in regard to my application, process during treatment, after-care planning, and final discharge report.

REFERRAL WORKER:		ORGANIZATION/AGENCY:	
Address:	City:	Province:	Postal Code:
Email:	Business Phone:	FAX:	
Alternate Contact Worker: (For emergency situations and/or if Referral Worker is not available)		Phone:	

______________________________ ______________________________
Applicant's Signature Date

______________________________ ______________________________
Referral/Alternate Worker's Signature Date

REFFERAL INFORMATION

Beaver Lake
COUNSELLING

Referral Worker		Title:
Agency:		
Daytime Phone:	Emergency Phone:	Fax:
Address:		
Funding Agency: (Please advise if cost shared.) (Will be invoiced at the end of the Program.)		
Contact Person:	Phone Number:	

Applicant Authorization

I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Beaver Lake Counselling Services.

____________________________ ______________________
Applicant Signature YYYY/MM/DD

____________________________ ______________________
Referral Signature YYYY/MM/DD

Send completed application to BLCS:

Fax: 1.807.937.4439 Attention: Intake Worker

Email: counselling@beaverlakecamp.org

All information contained in this application will be treated in accordance with BLCS's privacy and confidentiality policy. (See: beaverlakecamp.org/privacy-policy/)

THIS APPLICATION IS VALID FOR ONE YEAR AFTER THE DATE SIGNED.