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PREVENTION WEEK

Application form for the Wanaki Center

Application Procedures

Revised August 2018

To fill out the form, you can print and fill it out in writing. Remember that the form must be signed by all parties concerned.

Wanaki's application package contains two (2) sections:

Section 1: What you should know before you apply and In-house responsibilities

Section 2: Client Section

STEP 1: Wanaki must receive the completed application before we can proceed with our clinical assessment.

STEP 2: Once Wanaki has received all sections of the application, the Center will complete their clinical assessment within 7 working days. The Center's decision to accept or refuse the client application will be provided in writing within this time period.

STEP 3: Once a client application has been assessed as admissible for the Prevention Week the client or referral will be faxed the admission decision form. Upon receipt of this document, the form must be faxed back to Wanaki within 7 days with the client and referral worker's signature confirming their agreement to attend.

STEP 4: Once Wanaki has received the signed admission decision form as accepted by the client and referral worker, the community is then responsible to arrange the travel to and inform the Wanaki Center before the Prevention Week.

Any changes in the client's treatment request or admission must be provided to the center in writing by fax as soon as possible, such as legal, medical or family situation.

Please ensure that all sections are signed and dated as Wanaki Center will not process an application that is not signed and/or dated by all significant parties.

The Prevention Week intakes are done on **Sunday and we ask that clients be in before 2:00pm.**

Please ensure that the application is legible.

What do I need to know about the Wanaki?

- There are 4 cardinal rules:
    - No use of alcohol or drugs during the treatment
    - No violence of any kind
    - No intimate contact
    - No smoking in the building

- If you are accepted for the Prevention Week you must ensure that your personal and financial needs are met prior to entering the treatment center (i.e. banking issues, welfare, etc.). There will be a designated time for you to call your financial institutions to check bank balances. The Wanaki Center will not endorse any cheque on behalf of the resident.

- When you enter the Wanaki Center for treatment, you will have your personal belongings thoroughly searched upon entrance. All products and/or medications which contain alcohol and/or mood altering substances will be withheld by Wanaki. All prescribed medications will be held and allocated to the resident by a Counsellor or Program Facilitator. If any illegal drugs are found, your treatment will be terminated.

- No overnights outside Wanaki unless exceptional circumstances arise.

- You are permitted to take medication including over-the-counter or non-prescribed medication (including vitamins) but it must be prescribed by your physician/doctor. Medication that may alter the behaviour of the resident's capacity to function within treatment must be evaluated by the treatment team.

- There will be no access to the telephones during your stay unless there is an emergency.

- You are required to bring the following items;

  - ✓ Valid medical card
  - ✓ Toothpaste and toothbrush
  - ✓ Hairbrush or comb
  - ✓ Shaving gear, shampoo, deodorant, Q-tips (no products with alcohol)
  - ✓ Sleep wear
  - ✓ Contact lens and contact solution (if applicable)
  - ✓ Feminine products (if applicable)
  - ✓ Clothing to adapt to the season he/she is entering
  - ✓ Sufficient cash/Interact card/Credit card
  - ✓ Prescription medication (for 1 week, if applicable)
  - ✓ In house footwear (ex. shoes, slippers)
  - ✓ Personal identification cards (Minimum 2)

  Optional articles that you can bring:

  - ✓ A traditional skirts for ceremonies (women)
  - ✓ A ribbon shirt (men)
  - ✓ Hand drum or musical instrument (optional)

- The Algonquin medicines will be supplied at the Wanaki (sage, tobacco, sweet grass and cedar), so no need for you to bring your own.

I _____have reviewed these conditions to admission and understand that if certain conditions are not respected, this will result in an infraction report or my termination from the center.

_____ _____

Client Signature Date

_____ _____

Referral Signature Date

Responsibilities of people coming for the Prevention Week:

Daily Living Responsibility

- I will be given a wake-up call by the Program Facilitator on duty once every morning, Monday to Friday at 7:00am. If I have kitchen duty I will be provided a wakeup call a half hour earlier since I will be required to shower before reporting to kitchen duty. I must be out of my bedroom by 7:30am.

- A typical day for the Prevention Week will be as follows:
    - Breakfast from 7:30am to 8:15am
    - Distribution of medicine where applicable (hours are posted in your room)
    - Program begins at 8:30 with the opening of the circle which includes smudging
    - A walk will be done before the start of the workshops
    - Lunch from 12pm to 12:45pm
    - Program begins at 1pm
    - Closing circle
    - Personal time
    - Supper from 5pm to 5:45pm
    - Evening activity
    - Personal time
    - Bed time (lights out at 11pm)

- I am required to keep my personal room clean and tidy (i.e. making my bed each day, clean washrooms etc..).

- I'm responsible to work to my best ability on my 4 aspects:
    - Physical (walking, exercise DVD, using the gym, going up and down the stairs)
    - Mental (paying attention during the workshops, reading, learning from others)
    - Spiritual(smudging, praying, meditation, offering tobacco)
    - Emotional (writing in my journal, sharing in the circle)

Wanaki Structure Responsibility

- Respect safety procedures which will be shared with you during the tour of the facility
    - There is a register to be signed at the front exit if I intend to leave the center for an outdoor activity.
    - I understand that I must remain on the Wanaki grounds unless I am accompanied by a member of the Wanaki team.

- Kitchen duty: there are 2 residents to help in the kitchen, set the table, clean the kitchen area and dining room, clean the pots and pans, load the dishwasher and take the garbage outside. These 2 residents are also responsible for placing the chairs in the program room. Please advise us if you are sick. The schedule will be posted in the kitchen.

- Please note that the kitchen will be locked at 6:00 PM daily. Snacks are provided in the dining area.

- A laundry schedule will be posted in the kitchen. You will be sharing the washer and dryer with your roommate on the day you have kitchen duties. Laundry hours are from 4:00pm to 10:00pm

- Television hours are posted beside the television sets.

- For safety reasons, you are not permitted to use any personal music devices such as an MP3, an IPod etc.

- Junk food in the center:
    - We try to promote health eating so we ask that you don't bring in any junk food into the Center.

Respect

- I will respect the elders and their teachings.
- I am committed to respecting my own personal boundaries and that of the others.
- I will respect the personnel and Wanaki property.
- I will respect confidentiality.
- I will respect cultural and spiritual diversity.
- I will treat my colleagues as brothers and sisters.
- I will respect appropriate dress wear within the centre and not wear clothes with logos that can be perceived as offensive or promoting drugs/alcohol.
- I will use appropriate language and manners.

I _____, have reviewed these in-house responsibility. I also understand that if certain rules are not respected, this will result in an infraction report or my termination from the center.

APPLICATION FOR PREVENTION WEEK
PREVENTION PROGRAM 2018

CRITERIA FOR APPLYING:

- WE ASK INDIVIDUAL TO BE ABSTINENT FOR AT LEAST 3 WEEKS BEFORE ARRIVING.
- NOT MANDATED BY THE COURTS
- MOTIVATED TO CONTINUE ON THEIR HEALING JOURNEY

DATE OF THE APPLICTION: _____/_____/_____ **FILE NUMBER:** _____
DAY MONTH YEAR

IDENTIFICATION OF THE APPLICANT

NAME: _____ **FIRST NAME:** _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ □ **MALE** □ **FEMALE**
DAY MONTH YEAR

1- HOME ADDRESS: _____ _____ _____
NUMBER STREET APARTMENT

_____ _____ _____
CITY PROVINCE POSTAL CODE

PHONE NUMBER: HOME: ( ) _____/_____ CELLPHONE: ( ) _____/_____

2- FIRST LANGUAGE: □ FRENCH □ ENGLISH □ ABENAKI □ ALGONQUIN □ ATIKAMEKW
□ CREE □ MI'GMAQ □ MOHAWK □ INNU □ NASKAPI
□ INUKTITUT □ OTHER, PLEASE SPECIFY: _____

3- LANGUAGE OF USE: □ FRENCH □ ENGLISH □ OTHER, PLEASE SPECIFY: _____

4- HEALTH INSURANCE NO.: _____ **EXPIRATION:** _____/_____
YEAR MONTH

☐ RENEWAL REQUEST TO BE MADE ON: _____/_____/_____
DAY MONTH YEAR

5- BAND NUMBER: _____ **EXPIRATION:** _____/_____
MONTH YEAR

☐ RENEWAL REQUEST TO BE MADE ON: _____/_____/_____
DAY MONTH YEAR

7- CIVIL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED □ COMMON-LAW

8- NUMBER OF DEPENDENT CHILDREN: _____ **CUSTODY:** □ SHARED □ FULL-TIME

9- NUMBER OF CHILDREN IN FOSTER CARE: _____

PLACEMENT AGENCY NAME: _____

FOSTER CARE WORKER NAME: _____

PHONE#: ( ) _____/_____

10- SPECIFY THE CHILDREN'S AGES: 1- ____ 2-____ 3- ____ 4- ____ 5- ____

11- OCCUPATION:
□ FULL-TIME EMPLOYMENT □ PART-TIME EMPLOYMENT □ UNEMPLOYED
□ FULL-TIME STUDIES □ PART-TIME STUDIES □ AT HOME
□ VOLUNTEER □ OTHER: _____

12- NUMBER OF SCHOOL YEARS COMPLETED: _____

13- MOTHER OR GUARDIAN: _____ _____
LAST NAME (AT BIRTH) FIRST NAME

14- FATHER OR GUARDIAN: _____ _____
LAST NAME FIRST NAME

15- SPOUSE: _____ _____
LAST NAME (AT BIRTH) FIRST NAME

16- CONTACT IN CASE OF EMERGENCY: _____ **PHONE#:** ( ) _____/_____
CELL #: ( ) _____/_____

RELATIONSHIP: □ PARENTS □ SIBLING □ FRIEND □ OTHER-SPECIFY: _____

CAN WE LEAVE A MESSAGE? □ YES □ NO **IF SO,** TO WHOM? _____

17- APPLICANT'S AVAILABILITY: □ AM □ PM □ EVENING **PERSON WITH REDUCED MOBILITY:** □ YES □ NO

18- HAVE YOU EVER RECEIVED ADDICTIONS SERVICES? □ YES □ NO

19- HAVE YOU EVER BEEN FOLLOWED EXTERNALLY? □ YES □ NO **IF SO,** SPECIFY: _____

20- HAVE YOU EVER BEEN IN THERAPY? □ YES □ NO **IF SO,** NUMBER OF TIME**:** _____

IF SO, DATE OF THE LAST THERAPY**:** _____/_____/_____ **DURATION OF THERAPY:** _____
DAY MONTH YEAR

LOCATION: □ WAPAN □ WANAKI □ ONEN'TO: KON
□ MIAM UAPUKUN □ MAWIOMI □ WALGWAN
□ OTHER, PLEASE SPECIFY: _____

21- DID YOU OR YOUR PARENTS EVER ATTEND A RESIDENTIAL SCHOOL? □ YES □ NO
22- HAVE YOU EVER HAD A PERIOD OF ABSTINENCE? □ YES □ NO **IF SO,** HOW LONG? _____
WHERE? □ COMMUNITY □ IN CENTRE □ OTHER: _____
ANYTHING ELSE TO ADD: _____

PATTERN OF RELAPSE

WHAT DOES PREVENTION MEAN TO YOU?

_____

_____

HAVE YOU THOUGHT OR HAVE YOU RETURNED TO CONSUMING?

_____

_____

WHAT IS HAPPENING THAT HAS CAUSED YOU TO POSSIBLY THINK OF CONSUMING AGAIN?

_____

_____

ARE THERE ANY TRIGGERS, WARNING SIGNS OR AT RISKS PLACES THAT YOU BELIEVE IMPACTED YOUR RELAPSE?

- ☐ PEOPLE THAT USE
- ☐ BARS
- ☐ MY FAMILY
- ☐ BOREDOM
- ☐ MUSIC
- ☐ FEAR OF CHANGES
- ☐ LACK OF SUPPORT
- ☐ ISOLATION (IN ABSTINENCE)
- ☐ GRIEF
- ☐ LIFE PRESSURES (STRESS) - LEGAL
- ☐ FINANCIAL PROBLEMS

- ☐ NOT CHANGING FRIENDS, PARTNERS
- ☐ PEER PRESSURE (WEAK BOUNDARIES) – BULLYING
- ☐ LACK OF MOTIVATION
- ☐ LACK OF FEELING SECURE
- ☐ UNRESOLVED ANGER
- ☐ FALSE HOPES
- ☐ UNRESOLVED TRAUMA
- ☐ NOT ENOUGH EDUCATION AROUND LIFE SKILLS

WHAT DO YOU WANT TO WORK ON WHILE YOU'RE IN TREATMENT?

- ☐ COMMUNICATION
- ☐ CONFLICT RESOLUTION
- ☐ BOUNDARIES
- ☐ GAMBLING
- ☐ ANGER
- ☐ FEAR
- ☐ PHYSICAL ASPECT
- ☐ TIME MANAGEMENT
- ☐ BUDGETING
- ☐ WHO AM I (SELF-ESTEEM VS SELF-IMAGE)
- ☐ PROBLEM SOLVING
- ☐ DEALING WITH BOREDOM
- ☐ POSITIVE REINFORCEMENT
- ☐ HOW TO ACCEPT SUCCESS
- ☐ WHAT DO YOU USE TO COPE? - SELF-AWARENESS

WHAT ARE YOUR STRENGTHS AND POINTS TO IMPROVE ON?

_____

_____

HOW MUCH POWER HAVE YOU GAINED OVER YOUR SUBSTANCE 1-10:

ALCOHOL _____

DRUGS _____

GAMBLING _____

HOW WOULD YOU GAGE YOUR CRAVINGS ON A SCALE OF 1-10?

_____

TELL US IN YOUR OWN WORDS WHY WE SHOULD ACCEPT YOUR APPLICATION.

_____

_____

_____

BY WHO WERE YOU REFERRED?

□ FRIEND □ PROFESSIONAL □ COLLEAGUE □ FAMILY MEMBER □ SCHOOL
□ HOSPITAL □ HEALTH CENTRE □ JUSTICE
□ SELF-REFERRAL

OTHER, PLEASE SPECIFY: _____

REFERRER: _____ _____
LAST NAME FIRST NAME

REFERRAL ORGANIZATION NAME: _____

PHONE#: ( ) _____ - _____

ADDICTION ISSUE

□ ALCOHOL □ DRUGS □ MEDICATION □ GAMBLING □ CYBER DEPENDENCY

OTHER, PLEASE SPECIFY: _____

WHAT IS YOUR FIRST CHOICE OF SUBSTANCE? _____

HAVE YOU DEVELOPED ANOTHER EXCESSIVE BEHAVIOUR? □YES □NO

DO YOU HAVE SOMEONE IN YOUR ENTOURAGE WHO IS STRUGGLING WITH ONE OF THE FOLLOWING PROBLEMS?

GAMBLING: □ SPOUSE □ CHILD □ FAMILY AND/OR **ADDICTION:** □ SPOUSE □ CHILD □ FAMILY

OTHER, SPECIFY: _____ **OTHER, SPECIFY:** _____

PART 1

COMPLETED BY: _____ DATE: _____/_____/_____
DAY MONTH YEAR

TITLE: _____

PHONE#: ( ) _____/_____

PLEASE PRINT YOUR NAME.

26-CONSUMPTION

SUBSTANCES	FREQUENCY OVER THE PAST 3 MONTHS (#1)	FREQUENCY IN THE LAST WEEK (#1)	QUANTITY PER DAY	ADMINISTRATION METHOD (#2)	HOW LONG HAS YOUR CONSUMPTION BEEN PROBLEMATIC?	DATE OF THE LAST CONSUMPTION?
DEPRESSANTS						
ALCOHOL (BEER, WINE,…)						___/___/_____ D M Y
INHALANTS (GAS, GLUE…)						___/___/_____ D M Y
STIMULANTS						
AMPHETAMINE (SPEED, PEANUT, CRYSTAL METH, RITALIN…)						___/___/_____ D M Y
COCAINE (POWDER, FREEBASE, CRACK…)						___/___/_____ D M Y
DISRUPTIVES						
CANNABIS (WEED, HASH…)						___/___/_____ D M Y
ECSTASY (MDMA)						___/___/_____ D M Y
P.C.P.						___/___/_____ D M Y
KETAMINE						___/___/_____ D M Y
PSILOCYBINE (MAGIC MUSHROOM)						___/___/_____ D M Y
L.S.D. (BLOTTER, ACID…)						___/___/_____ D M Y
DRUGS: SEDATIVES / ANALGESICS						
ANXIOLYTICS (XANAX, ATIVAN, LORAZEPAM, DIAZEPAM, VALIUM)						___/___/_____ D M Y
HYPNOTICS (DALMANE, RESTORIL, HALCION, MOGADON…)						___/___/_____ D M Y
BARBITURATES (FIORINAL, SÉCONAL, PHÉNOBARBITAL…)						___/___/_____ D M Y
OPIATES (OXYCONTIN, CODÉINE, DEMEROL, DILAUDID, MORPHINE…)						___/___/_____ D M Y
METHADONE (ALTERNATIVE TREATMENT FOR OPIATES)						___/___/_____ D M Y
DRUGS: ANTIPSYCHOTICS / ANTIDEPRESSANTS / MOOD STABILIZERS						
ANTIPSYCHOTICS (SEROQUEL, RISPERDAL, ZYPREXA)						___/___/_____ D M Y
ANTIDEPRESSANTS (CELEXA, PAXIL, PROZAC, ZOLOFT…)						___/___/_____ D M Y
MOOD STABILIZERS (LITHIUM, EPIVAL, TEGRETOL)						___/___/_____ D M Y
OTHERS						
SPECIFY: _____ _____						___/___/_____ D M Y

LEGEND #1	
CONSUMPTION FREQUENCY	
1.	EVERY DAY
2.	3 TIMES AND + PER WEEK
3.	ONCE OR TWICE PER WEEK
4.	ON WEEKEND
5.	OCCASIONNALLY

LEGEND #2	
ADMINISTRATION METHOD	
1.	ORAL
2.	NASAL
3.	SMOKED
4.	INJECTED □ INTRAMUSCULAR OU □ INTRAVENOUS
5.	OTHER, SPECIFY: _____

PSYCHOLOGICAL STATE

HAVE YOU EVER BEEN FOLLOWED BY A MENTAL HEALTH PROFESSIONAL?

□ YES □ NO

- □ NAADAP WORKER
- □ PSYCHOLOGIST IN COMMUNITY
- □ COUNSELLOR IN COMMUNITY
- □ MENTAL HEALTH WORKER

COULD WE HAVE ACCESS TO YOUR FILES? □ YES □ NO

DO YOU HAVE A MENTAL HEALTH DIAGNOSIS?

□ YES □ NO

IF SO, PLEASE SPECIFY: _____

HAVE YOU EVER EXPERIENCED ANY OF THESE PROBLEMS?

REASONS	CURRENTLY	PREVIOUSLY	COMMENTS
SUICIDAL IDEATION	□	□	
ATTEMPTED SUICIDE	□	□	
SELF-MUTILATION	□	□	
FEELINGS OF DEPRESSION	□	□	
DEEP ANXIETY	□	□	
BEHAVIOURAL PROBLEM (AGGRESSIVENESS, ACTING OUT, VIOLENCE)	□	□	
LOSS OF INTEREST/ LACK OF MOTIVATION	□	□	
HALLUCINATIONS/PARANOIA	□	□	
ISOLATION	□	□	
SOCIAL PHOBIA	□	□	
DELIRIUM	□	□	
EATING DISORDER	□	□	
SLEEPING DISORDER	□	□	
OTHER: _____	□	□	

DO YOU TAKE MEDICATION?

□ YES □ NO

IF SO, PLEASE SPECIFY: _____

WHO IS YOUR PHYSICIAN?

PROFESSIONAL : _____/_____
NAME TITLE

PHONE#: ( ) _____ - _____

DATE: _____

LAST VISIT: _____/_____/_____ **NEXT APPOINTMENT:** _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

CULTURAL AND SPIRITUALITY

WHAT SPIRITUAL/RELIGIOUS BELIEFS DO YOU FOLLOW?

_____

_____

ARE YOU INTERESTED IN LEARNING GENERIC ALGONQUIN FIRST NATION CULTURAL AND SPIRITUAL TEACHINGS?

□ YES NO

NOTE: THE CLIENT WILL NEED TO BE PRESENT FOR THE CEREMONIES, BUT WILL NOT NEED TO BE AN ACTIVE PARTICIPANT.

PHYSICAL CONDITION

MEDICAL CONDITIONS TO MONITOR OVERSEE

ARE YOU PREGNANT? □ YES □ NO **IF SO,** SINCE HOW LONG? _____/MONTH(S)

DO YOU HAVE A CHRONIC DISEASE?

□ HIV □ ASTHMA □ HEART DISORDER □ LUNG DISORDER
□ DIABETES □ HEPATITIS □ EPILEPSY □ HYPERTENSION
□ TUBERCULOSIS (TB) □ OTHERS: _____

DO YOU HAVE ANY ALLERGIES? □ YES □NO

IF SO, WHAT ARE YOU'RE ALLERGIES? _____

ARE YOU BEING MEDICALLY-MONITORED FOR CHRONIC DISEASES MENTIONED ABOVE OR OTHER? (CURRENTLY)

□ YES □ NO

IF SO, WAS YOUR PHYSICIAN ADVISED OF YOUR SERVICES REQUEST? □ YES □ NO

PROFESSIONAL : _____/_____
NAME TITLE

PHONE#: ( ) _____ - _____

DATE: _____

LAST VISIT: _____/_____/_____ **NEXT APPOINTMENT:** _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

ARE YOU TAKING MEDICATION FOR PHYSICAL PROBLEMS?

□ YES □ NO

IF SO, SPECIFY: _____
_____

ARE YOU EXPERIENCING TROUBLE SLEEPING?

□ YES □ NO

IF SO, PLEASE SPECIFY: _____
_____

37- ARE YOU EXPERIENCING TROUBLE EATING?

□ YES □ NO

IF SO, PLEASE SPECIFY: _____
_____
_____
_____

LEGAL SITUATION:

DO YOU PRESENTLY HAVE ANY LEGAL ISSUES? YES NO

A. ARE YOU ON PAROLE? YES NO IF YES, UNTIL (Y/M/D): _____

B. ARE YOU ON PROBATION? YES NO IF YES, UNTIL (Y/M/D): _____

C. IS THIS A COURT ORDER TO ATTEND TREATMENT? YES NO

D. ARE THERE ANY OTHER COURT APPEARANCES REQUIRED? YES NO IF YES, UNTIL (Y/M/D): _____

E. HAVE YOU EVER BEEN INCARCERATED? YES NO IF YES, HOW LONG AGO: _____

F. WHAT WERE THE CHARGES? _____

G. ARE THERE ANY PENDING CHARGES? _____

IF YOU ANSWERED YES TO A OR B, PLEASE PROVIDE THE CONDITIONS FOR PAROLE OR PROBATION. IF YOUR ARE REQUIRED TO APPEAR IN COURT PLEASE INDICATE THE DATE:

_____
_____

MOTIVATION LETTER (WRITTEN BY CLIENT)
****PLEASE ENSURE YOUR WRITING IS LEGIBLE****

INTERVENER OBSERVATIONS

PLEASE NOTE YOUR COMMENTS FOLLOWING THE MEETING WITH THE CLIENT: (EX: NERVOUS, INCOHERENT, POOR HYGIENE…)

_____
_____
_____
_____
_____

FILE REFFERAL

A. □ INDIVIDUAL MEETING ANTICIPATED DATE:
_____

B. □ NURSE PLEASE SPECIFY:
_____

C. □ OTHER FIRST-LINE INTERVENER PLEASE SPECIFY: _____

D. □ REHABILITATION CENTRE ANTICIPATED DATE:
_____

E. □ EXTERNAL RESOURCES PLEASE SPECIFY:
_____

F. □ OTHER RESOURCES PLEASE SPECIFY:
_____

COMMENTS

_____
_____
_____
_____
_____
_____

PART 2

COMPLETED BY: _____ DATE: _____/_____/_____
DAY MONTH YEAR

TITLE: _____

PHONE#: ( ) _____/_____

PLEASE PRINT YOUR NAME

_____ _____
_____ _____
Client Signature Date

_____ _____
Referral Signature Date