



Helping Spirit Lodge Society

HELPING SPIRIT LODGE SOCIETY APPLICATION FORM

Date Application Submitted: _____

1) PERSONAL INFORMATION

Name: _____ Age: _____ Marital Status: _____

Current Address: _____

Last Address: _____

Email: _____ Phone Number: _____

Safe Message Number: _____

Nationality: _____ Identify as Aboriginal: _____ Aboriginal Status: _____

Band: _____ Are you connected with them, if not, would you like to reconnect? _____

Referred by: _____ Phone number: _____

Social Worker's name: _____ Agency: _____ Phone number: _____

Emergency contact name, number and relationship: _____

2) CHILDREN INFORMATION

Disclaimer - Obligation to Report to MCFD: Helping Spirit Lodge is responsible to secure the safety of all minors, in and out of care, and will report any circumstance where the child's wellbeing is at risk of harm.

Do you have children? If so, how many?

Accompanying children

Name: _____ Age: _____ Custody: _____

Name: _____ Age: _____ Custody: _____

Name: _____ Age: _____ Custody: _____

Name: _____ Age: _____ Custody: _____

Is there anything that we need to know about your child/ren? (i.e. Allergies, Medication, Behaviour concerns)

3) HISTORY OF ABUSE

Type of Abuse: Physical, Sexual, Spiritual, Emotional, Psychological, Verbal, Financial, Other

How long have you been in the abusive situation / relationship? _____

Description of last incident/ incident that brought you here:

Do you have a restraining order? Yes or NO if yes please explain: _____

Have the children witnessed and/ or experience any kind of abuse? Please specify

Describe your CURRENT relationship with abuser:

Abuser information:

Name of Abuser: _____ Will abuser look for you? _____

Age: ____ Height: _____ Weight: _____ Hair color: _____ Eye Color: _____ Ethnicity: _____

Distinguishing Marks: _____

Last Known Address: _____

Place of Work: _____ Vehicle: _____ Color: _____

Police Record: Yes or No If Yes, please describe _____

Drug or Alcohol Issues? _____ Access to weapons? _____

Legal/ Police involvement: Protection order, court proceedings, custody arrangements or visitation arrangements we need to know about?

4) MEDICAL INFORMATION:

Family Doctor's name: _____ Phone: _____

Do you and your children have regular doctor check ups? _____ last seen? _____

Do you have any Physical or mental health issues? Please describe. If meds needed, please let us know.

Do your children have any physical or mental health issues? _____ if yes please describe and what medications are required.

Do you or your children struggle with addiction? If yes, please explain.

Have you tried to harm yourself or others, including your children, in the past? _____

Have you thought about harming yourself or others recently? _____

Have you ever attempted to take your life? _____

Have you experienced suicidal ideation? _____

5) EDUCATION AND WORK EXPERIENCE

What was your last grade completed? _____ Year: _____

Have you taken any training/ retraining or upgrading courses? _____

Year: _____ Course: _____

Do you plan to go back to school? If yes, have you contacted the program yet?

Are you currently employed? If yes, please specify _____

What is your past work experience?

Type of work	Full/ Part time	Year	Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you plan to work? _____ Do you have a current resume? If yes, have you contacted any agencies? Please explain

6) HOUSING

When was the last time you had stable housing? _____

Have you previously stayed at any other Transition Houses? Yes / No, If Yes how long ago?

Have you applied for other housing? Please list all supports and services you are connected to at the moment (I.e. BC Housing, Lu'ma, VNHS)

Do you have own furnishings? (HSLs – SW provides furniture and outside furniture is not permitted)

7) FINANCIAL INFORMATION

Do you have a source of income? Please specify _____

What is your monthly income? Please specify if you are receiving any income assistance at the moment. (I.e. Disability, child support, child tax benefit, Employment insurance)

Do you have an account solely in your name? _____

Do you need any support filing for income assistance, family maintenance etc.? _____

8) SUPPORT AND SERVICES NEEDED

Do you have support persons/ network in place? Family, Professional, Children's Support, Elders, church

What services so you need assistance with? (I. e. Counselling services, parenting skills, stress management, life skills, etc.)

Are you or your children presently involved with other support agencies or groups (i.e. social workers, mental health counselling, housing, MCFD)? Please specify

9) INTENTIONS

Why are you making this application for the spirit way second stage program?

What do you hope to get out of spirit way programs?

What does healing look like for you? Do you practice any self-care?



Helping Spirit Lodge Society
HELPING SPIRIT LODGE SOCIETY
CONFIDENTIALITY FORM



At Helping Spirit Lodge Society (HSLs), confidentiality is defined as "a respect for the wishes of the client regarding her desire for anonymity with reference to the release of information, purposeful or inadvertent, to any person or organization other than HSLs staff."

It is of the utmost importance that all names of program participants and the whereabouts of the families be kept secret. The safety of the women and the success of the program depend on this.

Any information revealed to a staff member of the Second Stage Program is shared with the other HSLs staff members.

I HAVE READ, AGREED AND WILL COMPLY WITH THE ABOVE STATEMENT

Signature _____ **Date** _____

Witness _____ **(sign and name)**

OTHER CLIENT REQUIREMENTS

I have read with HSLs staff and understand the SPIRIT WAY SECOND STAGE PROGRAM RULES and POLICIES.

I agree to abide by the rules and policies and will accept the consequences if I should breach any of the policies or rules.

Signature _____ **Date** _____

I am aware of the emergency exits and fire drill procedures.

Signature _____ **Date** _____



**Helping Spirit Lodge Society
Application for Admission**



Residents Name (last, first, initial)	Date of Birth (YYYY-MM-DD)	BC Care Card
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At Spirit Way Programs, we require a true list of resident's medication and any mental health diagnosis so we effectively support the residents during their time of need.

Medications (if more room is needed, attach list)								
Medication	Dose	Route	Frequency	Reasons Given	Start Date	End Date	Prescribed by	Phone Number

Medication Mandatory _____ Optional: _____ Holistic: _____

Please remind client that in order to be accepted to Spirit Way Programs they need to:

- Be well enough to participate in program, remain alcohol and drug free during their residency.
- Ensure any new medication not listed above is reported to Program Supervisor
- If the clients medical or psychological condition changes prior to their scheduled admission, the Spirit Way Programs supervisor must be contacted.

Physicians name	Signature	Date (YYYY-MM-DD)		
Mailing Address				
City/Town	Province	Postal Code	Phone	Fax
Primary Physician's Name (if different than above)			Phone	Fax
Other (e.g. psychiatrist or other specialist relevant to this admission)			Phone	Fax

* Please ensure the medical portion is signed and stamped by the medical physician who completed the forms. Failure to do so may cause delay in processing your application.

** Please discuss any restricted medications at your initial appointment to avoid delays in processing your application

Physician's Stamp



Helping Spirit Lodge Society
I agree to my responsibilities



Waiver to Release Information Form

Carefully read the following:

I understand in order to be approved for residency, I must remain alcohol and drug free. If I arrive to the residency under the influence I will receive a warning letter and may jeopardize my residency.

I understand Spirit Way Programs will not assume any responsibility for any personal costs I may incur during residency.

I understand and agree to accept and attend all program as directed by Spirit Way Programs, includes special guests, lectures, cultural activities. etc.

Signature: _____

Date (YYYY-MM-DD) _____

Waiver to Release Information

I, _____ authorize any professionals listed on this application (Referrals, Medical Staff, Social Workers, Probation Officers) to release to Spirit Way programs any information, including but not limited to, medical diagnosis, psychological and or/psychiatric assessments, evaluations and legal matter pertaining to my well being. This also allows Sprit Way to communicate with the listed aforementioned.

Name of Agency: _____ Name of Contact: _____ Signature: _____

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Name of Agency: _____ Name of Contact: _____ Signature: _____

Signature: _____

Date (YYYY-MM-DD) _____

Authorize a copy/list of prescriptions

I, _____ authorize Spirit Way Programs to obtain a copy of my prescriptions for the duration of stay with Spirit Way Programs.

Signature: _____

Date (YYYY-MM-DD) _____

Restricted Medications (Require ED Approval with Doctor Consult)

Opioids: Oxycodone, Methadone (Methadol, Methadose) Suboxone

Benzodiazepines: Ativan, Valium, Xanax, Restoril

Psychostimulants: Dexedrine, Ampetamine, Adderall XR, Ritalin, Biphentin or

Miscellaneous: Marijuana without a medical card