2025

Kackaamin
FAMILY DEVELOPMENT CENTRE

Family Program | Adult Application

www.kackaamin.org T. 250.723.7789 F. 250.723.5926

Kackaamin Family Development Centre sits on Hupacasath and Tseshaht First Nation unceded territories. We walk respectfully with the intention of helping people on their healing journeys, and practice with reciprocity, honest kindness and kind honesty.

Last Updated: 17 Jan 2025

Family Program | Adult Application

****** Please ensure this application is complete and sent with your Intake Checklist ******
****** or your package will be considered incomplete. ******

Dear Applicant,

Thank you for your interest in attending Kackaamin Family Development Centre. Our team is committed to providing families with a safe space for you and your family to come for healing.

If you are a single parent, we recommend that you bring a supportive family member along with you to help care for you and your children. The healing program is a period of emotional, spiritual, and mental growth and can be a tiring process.

If you feel you may be dependent on using alcohol, opioids or other strong substances, we strongly recommend attending individual treatment *prior* to attending treatment with your children.

This form is to be completed by the Applicant *and* Referral Worker. Please read and sign as indicated. All sections need to be completed and received in full to be considered "complete."

Please fax pages 4 – 14 to us at 250-723-5926.

For more program information, please visit our website: http://www.kackaamin.org.

Sincerely,

Kackaamin Family Development Centre

Applicant Initial _____ *Referral Worker Initial* _____

Section 1: Preparation (Stabilization)

Stabilization prior to attending treatment is a critical factor for Client success. This is so clients/families have reduced stress and distractions while they are working on their healing program. Here are some steps to help you prepare for the program:

1. STABILIZE

- **Safe** detox from alcohol & drugs ☐
- Housing ☐
- Legal matters settled including custody arrangements ☐
- Finances ☐
- Children live with the parent(s) ☐

2. WELLNESS PREP

- Glasses, dental, hearing aid ☐
- 6 Counselling Sessions ☐
- Medical check-up ☐

3. IS KACKAAMIN FAMILY TREATMENT THE RIGHT FIT?

- we cannot safely support detox on site
- we are unable to accept people with history/conviction of *sexual violence*
- we are not obligated to accept *court mandated* applicants
- ✓ BC/Yukon resident
- ✓ Ready to commit for 6 weeks of healing

4. APPLY

- Referral Worker to help fill out applications for each family member ☐
- Doctor or Nurse for Medical Section ☐
- Counsellor section ☐
- Teacher / children's support people ☐

5. INTAKE PROCESS

Our Intake Team will call to confirm the package was received.
If you'd like to be on the Cancellation List, please let the Intake Worker know on your call.

Our Wait List is usually 1-2 sessions. You & the Referral Worker will receive a confirmation letter with Dates and more info once a space opens up. ☐

Make arrangements for your finances, bills, travel ☐

6 WEEK FAMILY SESSION

Disconnect to reconnect

Individual, Family & Group Therapy

Connection
Community Supports

RESILIENT FIRST NATIONS FAMILIES THRIVING IN WELLNESS

Applicant Initial _____ *Referral Worker Initial* _____

Section 2: Informed Consent

To be reviewed by all Clients- including children and youth 12+yrs with their parent/caregiver. Please check after discussed to acknowledge:

- ☐ The Family Healing Program is six weeks long. Families often attend Kackaamin to work on their family's wellness, communication, healthy parenting, addictions and trauma recovery.
- ☐ Family Focus: **Children and youth are to be supervised at all times.**
- ☐ **Safety & commitment** to healing is required
- ☐ **No cell phones, smart watches, laptops, gaming consoles allowed**
- ☐ Limited internet access permitted and only for paying bills, etc. There are landlines in the cabins available for clients' use.
- ☐ Clients **must** stay onsite for the six-week program.
- ☐ Children **must** be living with the parents/applicants prior to attending the program and after program.
- ☐ **Shared custody:** other parent/caregiver(s) must be informed of the child(ren)'s attendance to the program.
- ☐ The Client family is responsible for their return travel if they leave or are discharged from treatment early.
- ☐ Families must arrive on Intake Day between 12pm-4pm.

- ☐ **FYI: Possible Reasons for Early Discharge from Program:**
  - Substance use
  - Unable or unwilling to participate in program/program guidelines
  - Ongoing bullying or aggression toward others, violence, damage to property, etc.
  - Concerns for safety and needs that cannot be met at Kackaamin
  - Incorrect/inaccurate information on application that impacts others safety

Client Signature: _____ Date: _____

Referral Signature: _____ Date: _____

Applicant Initial _____ *Referral Worker Initial* _____

Section 3: Admission Requirements

The following should be in place for client safety and to reduce stress for clients to come do their healing program:

Client safety is #1 Priority

Mental – Physical – Emotional – Social – Spiritual Safety

Physical SAFETY:

- ☐ **Detox prior to attending program.**
  KFDC Family Programs are for people who **do not require** detox and stabilization. *(opioid antagonist therapy is unable to be accommodated at KFDC at this time)*
- ☐ **Medical** check-up, including up-to-date medications, hearing aids, glasses, etc.
- ☐ **If there is Domestic Violence (or risk of)** please set up a time with us to discuss options.
- ☐ Adults with history or convictions of sexual violence are unable to attend. Please connect with our Rebuilding the Circle (RTC) team for treatment options.

Mental / Emotional SAFETY:

- ☐ Adults must be physically and mentally able to participate in our rigorous counselling, workshops and **group learning** *(sitting working with other clients for 3-4 hour periods at times).*
- ☐ **Bring a family support person to help** if your child(ren) typically has many resource workers, such as a learning disability.
- ☐ **Practice routine** before attending. Bedtime, reduce devices/gaming/tv screen time

Emotional SAFETY:

- ☐ **Counselling:** before and after treatment. Attending treatment impacts people in various ways. Having a support network is *needed.*
- ☐ **Continuity of Care**: The Referral Worker should maintain regular pre/post-treatment contact.
- ☐ **Parents attending with children must have full guardianship.**

Applicant Initial _____ *Referral Worker Initial* _____

Section 4: Applicant Information

Information required for our reporting and safety planning:

Adult Application			Date:
Legal Last Name:	Legal First Name:	Alias/Goes by:	
Date of Birth: *YYYY/MM/DD* _____/_____/_____	Self-Identified Gender:	Personal Health Number:	
Aboriginal Ancestry? ☐ YES ☐ NO	First Nation: Status #:		On-reserve ☐ Off-reserve ☐
Contact Information			
Home Address:		Email: Phone:	
Mailing Address: *Same as Home Address:* ☐		**Emergency Contact** Name: Relationship to Client: Emergency Contact #:	
Family Relationships			
Marital Status: ☐ Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Other:			
Current Living Arrangements: ☐ With my children & partner ☐ Single Parent ☐ Alone ☐ With extended family ☐ Recovery home ☐ Shelter ☐ Other			
Other			
School attendance ☐ Elementary ☐ Some high school ☐ Completed high school ☐ Additional training/Education ☐ College/University			
☐ Residential School (IRS) ☐ Indian Day School (IDS) ☐ Parent(s) or Grandparent(s) attended IRS ☐ Parent(s) or Grandparent(s) attended IDS			
Are you employed? ☐ No ☐ Part-time ☐ Seasonal ☐ Full-time ☐ Income Assistance ☐ Disability ☐ Other:			
Funding			
Funding is required for clients to get their ***groceries and miscellaneous needs*** while they attend. **Recommended Amounts:** *$175 - $200 per week for a 1-2 parent family with 1 child* *$200 - $250 per week for a 1-2 parent family with 2 children* *$250 - $300 per week for a 1-2 parent family with 3 children* *$300 - $350 per week for a 1-2 parent family with 4 or more children* **Funding will be paid for by:** ☐ FNHA ☐ MCFD / Usma ☐ Other: ☐ First Nation ☐ Self 2. **Travel arrangements and coverage by:**			

Applicant Initial _____ *Referral Worker Initial* _____

Guardianship		
Are MCFD or Delegated Aboriginal Agencies involved at any level?	☐ Yes ☐ No	If yes, please describe: Most recent Family Plan attached? ☐Yes ☐No
Are any of the children in care?	☐ Yes ☐ No	If yes, please describe: Most recent Family Plan attached? ☐Yes ☐No
Do you have any other children (e.g. adults, children not living in the home)	☐ Yes ☐ No	If yes, please describe:
Are there any outstanding child custody issues?	☐ Yes ☐ No	If yes, please describe:
Is the intention of attending treatment to have the children returned to you at the end of treatment?	☐ Yes ☐ No ☐ N/A	
Attach any relevant documents, orders, correspondence	☐ Supervision Order attached ☐ Safety Plan attached ☐ Shared guardianship- signed letter attached	

Children Attending (Applications attached)

First Name	Last Name	Age	Relationship to Applicant:	Living With Applicant? Y/N

The following information is to help us plan your family's care:

Family Goals

Wellness and Mobility Information
Are there any physical challenges or chronic health conditions that require special attention in any member of the family? *Please specify*: *Remember*, we encourage families to bring another family member as a Support Person to help if needed!
Any mental health diagnoses? ☐ N/A ☐ PTSD ☐ Depression ☐ Anxiety/Panic disorders ☐ ADHD ☐ FAS/FAE ☐ Brain/Head injury ☐ BPD ☐ Psychotic disorder ☐ Other:

Applicant Initial _____ *Referral Worker Initial* _____

Any history of: ☐ Suicidal Ideation ☐ Self-Harm ☐ Attempted Suicide – last attempt: _____ ☐ N/A	
Mobility Challenges? ☐Yes ☐No Info:	Require a wheelchair-accessible unit? ☐Yes ☐No
Reading/Writing/Hearing Challenges? ☐Yes ☐No Describe:	

Support Team

Addictions Support ☐ Medical team ☐ Individual treatment completed ☐ Community (AA, NA) ☐ Self-managed

Social Support:		**Counsellor:**
Family Support:		**Cultural Practices:**
Spiritual/Other:		

Can you share what strengths *you* have that have helped you get through hard times?

What are your family's strengths?

Substance Use & Treatment History

Have you attended treatment sessions before? ☐ Yes ☐ No

Treatment Centre:	Date:	Completed? ☐ Yes ☐ No
Treatment Centre:	Date:	Completed? ☐ Yes ☐ No

What was/is your primary substance of choice?

Age of first use:	How often?	Last use:	Hospitalized for it? ☐ Yes ☐ No

Other/second substance of choice:

Age of first use:	How often?	Last use:	Hospitalized for it? ☐ Yes ☐ No

Other:

Age of first use:	How often?	Last use:	Hospitalized for it? ☐ Yes ☐ No

Any concerns about addiction to any of the following?
☐ Prescription meds ☐ Tobacco ☐ Gambling ☐ Eating ☐ Gaming ☐ Internet (scrolling)
☐ Caffeine/Pop ☐ Sex/Porn ☐ Exercise ☐ Other:

Applicant Initial _____ *Referral Worker Initial* _____

Legal History

Do you have any current legal orders or legal involvement in place for any reason? Check below:

☐ No charges or convictions ☐ Meets Application Guidelines (see p. 5) –*skip to next section.*

☐ Yes, charged: Date(s): _____Charge(s): _____

_____

Relating to: ☐ Violence ☐ Sexual ☐ Drug-related ☐ Involved a minor ☐ Involved a partner

☐ No-contact order with current partner? ☐ Yes ☐ No Effective date: _____

☐ On Probation/Parole: Probation/Parole Officer Name: _____ Number: _____

E-mail:_____

Address: _____ Postal Code: _____

☐ Bound by Release Order (details): _____

☐ Pending charges (describe): _____

☐ Upcoming court date(s): _____

☐ Attached copy of Parole/Probation/Bail Order and contact information (<u>required</u> to review application)

Any other information you'd like to share:

Referral Information (*To be completed by Referral Worker)*

Referral Worker/Counsellor Name:		Title:
Agency:	Tel:	Fax:
Email:	Mailing Address:	

Is the applicant receiving counselling services from you? ☐ No ☐ Yes (see *Counselling Summary*) ☐ Other:

Was the Intake Checklist completed with you? ☐ No ☐ Yes

We strongly suggest Referral Workers support clients *after* they complete family treatment for a continuum of services. Will you be available to follow up with the applicant? ☐ No ☐ Yes

_____ _____

Referral Worker Signature **Date**

Applicant Initial _____ *Referral Worker Initial* _____

Consent

Consent for the Release of Confidential Information:

I, (applicant name) _____ hereby give permission for the Intake staff at Kackaamin Family Development Centre to contact my referral worker, counsellor, social worker, doctor/nurse, and my Bail/Probation Officer as indicated below for the release of pre-treatment information, disclosure of progress during treatment and aftercare planning and final discharge report if requested by the applicant.

Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail
Name	Agency	Phone / E-mail

Acknowledgment and Assumption of Risk

I understand that with the sharing of information, there is a rare risk of the data transfer being interrupted by persons other than the intended recipient. I understand that in the case of missing transferred data, this could result in an application not being deemed complete by the Kackaamin Intake team, leading to a delay or omission of service.

I understand that Kackaamin staff engages in case conferencing for the benefit of my treatment and healing.

I understand that the information collected and required for Kackaamin Intake will be stored and handled in a confidential manner, and that I may apply to access within the amount of time identified by the Freedom of Information and Protection of Privacy Act.

Release of Liability, Waiver of Claims, and Indemnity Agreement

I hereby agree as follows:

To waive all claims that I have or may have in future against Kackaamin Family Development Centre, its agents, directors, employees and representatives and other participants, all of whom are hereafter collectively referred to as Releases.

I have read, understood and agree with the statements in the Acknowledgement and Assumption of Risk portion of this document, and by assuming and acknowledging this risk, I completely absolve all Releases from any and all liability for loss, damage, injury or expense that I may suffer, that a third party may suffer or that my next of kin may suffer as a result of the release of information by the Releases, due to any cause whatsoever.

In entering into this agreement, I am not relying upon any oral or written representation or statements made by the Releases.

I have read and understood this agreement and I am aware that by signing this agreement I am waiving certain legal rights which I or my heirs, next of kin, executors, administrators or assigns may have against the release.

Questions regarding the collection of this information can be directed to the Intake team (Sadie Greenway or Nik Burton @ 250-723-7789).

_____ _____

Applicant Signature **Date**

Applicant Initial _____ *Referral Worker Initial* _____

Section 5: Medical Assessment (2 pages)

Medical Assessment (*To be completed by a physician or nurse*) p.1/2		
Date:	Applicant Name:	D.O.B.:
	Personal Health Number:	Allergies:
	Pharmacy:	Pharmacy #:
	Physician:	Physician #:

The Applicant named above is applying to attend a 6-week residential treatment facility. We strongly suggest that this is completed by a Medical Personnel (doctor, nurse) that regularly sees the Applicant.
Please complete the following information with the Applicant to support planning and safe delivery of service at our establishment.

Consent to Release Confidential Information:
I, _____ (Applicant name), hereby request and authorize _____ (Medical Personnel name) to release medical information pertaining to myself to Kackaamin Family Development Centre for the purpose of planning my care at treatment.

Applicant Signature	Medical Personnel's Name, Title	Date

Medications

Please attach a list of current medications including dose and reason for taking

1. Have you recently completed a medication review with the Applicant? ☐ No ☐ Yes
2. Is the Applicant taking medications as prescribed? ☐ No ☐ Yes

Substance Use and Withdrawal Support

Our Family Program requires Applicants to be detoxed and stabilized prior to attending. This is so they can do residential trauma healing safely, and so they can rebuild connection with their children.
We suggest Applicants who are dependent on substance(s) attend Individual Treatment and/or healing workshops *prior* to attending with their children/families.

Please screen your client for withdrawal management needs and refer to community services if needed.

1. Withdrawal management required? ☐ No (*skip to question 3*)
   ☐ Yes ☐ Referred to community agency
2. Is the Applicant accessing Opiate Agonist Therapy? ☐ No (*skip to question 3*)
   ☐ Yes

Prescribing Physician/NP:	Ph:	Fax:
Specify Replacement Type (e.g. Methadone, Suboxone, etc.):		Initial Dose:
		Current Dose:

3. Does the Applicant take prescribed medical marijuana (including CBD or THC)? ☐ No ☐ Yes, for:

Applicant Initial _____ *Referral Worker Initial* _____

MEDICAL HISTORY	Comments
Does the Applicant have any communicable diseases? ☐ No ☐ Yes	
Does the Applicant have any history of head trauma or cognitive impairment? ☐ No ☐ Yes	
Does the Applicant have a history of seizures? ☐ No ☐ Yes	
Does the Applicant have any chronic illnesses or conditions? ☐ No ☐ Yes	
Is the Applicant pregnant? ☐ No ☐ Yes	(If yes, how many weeks?)

TB SCREENING *(if entering into Panorama, refer to Panorama Entry Guide)*

This TB screening is to rule out **active TB**. Latent TB screening is not required for attending our treatment centre, but it may be beneficial to the Applicant and can be done at a later date.

TB Symptom Assessment

☐ Fever	☐ Cough (>3 weeks)	☐ Hemoptysis
☐ Chest pain	☐ Short of breath	☐ Fatigue
☐ Night sweats	☐ Lymphadenopathy	☐ Other:
☐ Unexplained weight loss	☐ Sputum production	

Has the Applicant had any recent exposure to TB? ☐ No ☐ Yes | Receiving TB treatment? ☐ No ☐ Yes

***If the Applicant has a cough or other symptoms consistent with active TB, complete TB Screening as indicated by BCCDC and fax to the appropriate services:**

If the Applicant lives:

- In a **BC First Nations community**, fax form to FNHA TB Services: 604-689-3302
- **Urban areas (off-reserve) Island Health:** fax 250-519-1505
- **All other areas, BCCDC**: fax 604-707-2690

TB HISTORY

Has the applicant ever had any of the following (check all that apply):

☐ Positive TST and/or IGRA result ☐ Contact with someone with active TB ☐ Treated for TB

RISK FACTORS

Certain risk factors post a risk of progression from Latent TB to Active TB, or increase the risk of exposure to TB. Check all that apply:

☐ Transplant:	☐ Chronic kidney disease/Dialysis	☐ Substance use
☐ Cancer (specify):	☐ HIV	☐ Tobacco use
☐ Immune suppressant medications:	☐ Diabetes	☐ Work or live in a correctional facility (past or current)
	☐ Homelessness, underhoused (past or current)	

Practitioner Signature: _____ Clinic Name or Stamp:_____

Applicant Initial _____ *Referral Worker Initial* _____

Section 6: Counselling Summary

Counselling Summary *(To be completed by the Counsellor and Applicant) p.1/2*		
Date:	Applicant Name:	D.O.B.:
	Counsellor Name:	Contact Info:

This form is to support the Applicant prepare to attend our 6-week family trauma healing program.

- We strongly suggest that attendees have regular counselling sessions prior to attending to ensure they and their family are successful in completing.
- Individual treatment is strongly recommended for individuals prior to attending family healing program.
- We strongly suggest that attendees have counselling support after attending to ensure a continuum of care, as the healing sessions at treatment can create vulnerabilities requiring additional support.

Please complete the following information with the Applicant to support planning and safe delivery of service at our establishment.

Consent to Release Confidential Information:

I, _____ (Applicant name), hereby request and authorize _____ (Counsellor Name) to release medical information pertaining to myself to Kackaamin Family Development Centre for the purpose of planning my care at treatment.

Applicant Signature	Counsellor Name, Title	Date

Has the Applicant completed *pre-treatment* appointments with you? ☐ No
☐ Yes, dates of sessions in the past 3 months:

Does the applicant have a *post-treatment* appointment set? ☐ No ☐ Yes, date:

Check all applicable boxes: ☐ PTSD ☐ Anxiety/Panic disorder ☐ Anger/Acting out ☐ Grief & Loss
☐ Sexual harm/abuse ☐ Family violence ☐ Family trauma ☐ Foster care
☐ Violence toward children or partner ☐ Other:

Is the Applicant willing to partake in healing through a **group setting**? ☐ No ☐ Yes

At this moment, do you perceive the Applicant is ready to attend family healing session? ☐ No ☐ Yes

Recommended preparations/tools for Applicant:

- ☐ Awareness that they will be addressing traumas while attending program
- ☐ Self-regulation techniques
- ☐ Safe withdrawal, addictions support, willingness to maintain sobriety
- ☐ Stabilized housing, guardianship, legal, health, etc.
- ☐ Ready to connect with their child(ren) and family to support their healing

Applicant Initial _____ *Referral Worker Initial* _____

Counselling Summary p.2/2
Summary of strengths:
Applicant's presenting problems:
Summary of issues being addressed in sessions:
Counsellor Signature: _____ Date: _____

Applicant Initial _____ *Referral Worker Initial* _____

Section 7: KFDC Process

1. The Intake Coordinator will contact the Referral Worker by email/phone to verify the intake package has been received.
2. A KFDC team member will contact the Applicant to begin planning treatment goals and answer questions. *Please let KFDC know if you would like to be placed on the cancellation list.*
3. Intake preparation process complete and Applicant/family are placed in the queue.
   - Applications that are within 6 months of intake require a phone call review with the client to check for changes, updates, etc.
   - No-shows, cancellations, deferred intakes: Applications will be held for one year. If we are unable to connect with the Applicant or Referral Worker, the application will be considered closed.
4. Once space opens, the Intake Coordinator contacts the Applicant and Referral Worker to confirm availability.
5. Once all pre-admission requirements are met, Intake Coordinator sends a confirmation letter to Client and Referral Worker including information:
   - Session Dates
   - What to Pack
   - General Guidelines

Thank you for your patience and time.

Kackaamin Family Development Centre

Applicant Initial _____ *Referral Worker Initial* _____