Grief & Loss

January 11 – 21, 2027

Please fax your application to the RTC Team: **250.723.5926**

www.kackaamin.org T. 778.421.8811 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: 11/19/2026

Section 1: Readiness

The Restoring Balance: Grief & Loss program is intensive and requires stability and sobriety.

Applications will be considered if applicants are:

- ✓ Not using alcohol, marijuana, or illicit substances regularly
- ✓ Support systems are in place for counselling after program completion
- ✓ Other concerns can be managed safely with Kackaamin resources, such as health/mobility

Applications cannot be considered if:

- ☐ Detox and withdrawal support is required (including short-acting OAT)
- ☐ Adults with a history or convictions of sexual violence are unable to attend. Please connect with our Rebuilding the Circle (RTC) team for treatment options.
  --If there is Domestic Violence (or risk of) with any of your family members who are applying, please set up a time with us to discuss options.

Section 2: Informed Consent



- ☐ **No devices allowed during group activities**
- ☐ Clients **must** stay onsite for the duration of the program.
- ☐ Clients must arrange their own travel to Kackaamin and arrive on Intake Day between 12pm-4pm. If discharged or they leave early, the client is responsible for their return travel arrangements.
- ☐ Program Guidelines:
  - Bag checks on arrival
  - We have a Medications Policy- medications are stored away in our Med Room
- ☐ **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

Section 3: Applicant Information

Information required for our reporting and safety planning:

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 ☐
ALLERGIES: (including any food allergies, smudging, etc.)			

Contact Information	
Home Address:	Email: Phone:
Mailing Address: *Same as Home Address:* ☐	**Emergency Contact Name**: Relationship to Client: Emergency Contact #:

Care Team Name	
Referral Worker:	Pharmacy:
Counsellor:	Other:

General Info
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:
Current Living Arrangements: ☐ With my children & partner ☐ Single Parent ☐ Alone ☐ With extended family ☐ Recovery home ☐ Shelter ☐ Other

The following information is to help us plan your care:

Wellness and Mobility Information	
Substance Use: Do you use alcohol, marijuana, or other drugs/substances? Please specify:	
Substance: Age of First Use:	How often is it used? Last use:
Substance: Age of First Use:	How often is it used? Last use:

Are there any **physical challenges or chronic health conditions** that require special care? *Please specify*:	
Mobility Challenges? ☐Yes ☐No Info:	Require a wheelchair-accessible unit? ☐Yes ☐No
Reading/Writing/Hearing Challenges? ☐Yes ☐No Describe:	
Any mental health diagnoses? ☐ N/A ☐ PTSD ☐ Depression ☐ Anxiety/Panic disorders ☐ ADHD ☐ FAS/FAE ☐ Brain/Head injury ☐ Borderline Personality Disorder ☐ Other:	
Any history of: ☐ Suicidal Ideation ☐ Self-Harm ☐ Attempted Suicide – last attempt: _____ ☐ N/A	
Do you have any significant losses in the past six months or so?	

Legal History

Do you have any legal orders or legal involvement? ☐ No charges or convictions –*skip to next section.*

☐ Yes -- Copy of applicable Legal Order and PO contact information is <u>required</u> to review application

☐ Release Order ☐ Upcoming court date(s): _____

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

E-mail:_____

City: _____

☐ <u>Prior</u> charges relating to: ☐ Violence ☐ Sexual ☐ Drug-related ☐ Involved a minor ☐ Involved a partner

Referral Information

Referral Worker/Counsellor Name:	Title:
Fax:	Email:

Referral Worker Signature	**Date**

Please have a doctor or nurse complete the Medical Section, pages 5- 6.

Page 7: In case we need to connect with your care team (Referral Worker, Counsellor, Doctor/ Nurse/ Pharmacist), please list them on the Consent Form, page 7.

Sincerely,
The RTC Team

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

The Applicant named above is applying to attend an 8-day residential treatment program. We strongly suggest that this is completed by a medical professional (doctor or nurse) who regularly sees the Applicant.

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 Programs require clients to be detoxed and stabilized prior to attending. This is so they can complete residential trauma healing safely.

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, Sublocade, etc.):		Initial Dose:
		Current Dose:

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

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	

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	☐ Shortness 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 increase the 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
☐ Immunosuppressant medications	☐ Homelessness, underhoused (past or current)	☐ Work or live in a correctional facility (past or current)
☐ Diabetes		

Practitioner Signature: _____Clinic Name or Stamp:_____

_____

Consent for the Release of Confidential Information:

I, (applicant name) _____, give permission for the Intake staff at Rebuilding the Circle – a department of Kackaamin Family Development Centre, to contact my referral worker, counsellor, doctor/nurse, and my Bail/Probation Officer, as listed below, to release pre-treatment planning information.

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 if transferred data is missing, the Kackaamin Intake team may not deem the application complete, leading to a delay or omission of service.

I understand that Kackaamin staff engage 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 my heirs, next of kin, executors, administrators or assigns, or I may have against the Release.

Questions regarding the collection of this information can be directed to the RTC Program Manager @ 250-723-7789.

Applicant Signature	**Date**

Thank you! Your information will help us plan client supports and resources for their time here.