Kackaamin
FAMILY DEVELOPMENT CENTRE

Rebuilding the Circle
Healing Session Application

WHAT IS REBUILDING THE CIRCLE?

Rebuilding the Circle (RTC) is a strengths-based continuum of comprehensive treatment services to heal the impacts of sexual harm in Nuu-chah-nulth families and communities. RTC is Quu?as based, trauma-informed, and holistic. We are on a journey of healing for all and restoring the strength of Nuu-chah-nulth communities.

Healing Sessions for those who have been harmed sexually

Applicants can expect a 4-week residential intensive trauma treatment, to support the integration of victim trauma. This group therapy model follows the psychodramatic curve of building safety, moving through trauma treatment, and leaving the session in an empowered place. This includes group safety, building a cognitive life raft, telling our stories, exploring shame, guilt, and relationships, grief, letting go, and reconnecting.

- **This Application is the first step in our intake process—additional information will be required through the clinical interview, including wellbeing, counselling, and child welfare or legal histories if applicable.**

- **The medical assessment is a requirement, but is not a barrier in assessing readiness for Rebuilding the Circle Programs.**

- **This Application, and the Intake process will ask applicants to reflect on how sexual violence has impacted themselves and/or their family system. The wellbeing and safety of applicants is important. Our team is here to work with the applicant, and their community referral worker/s to create support and safety.**

- **The Rebuilding the Circle Team can work with the referral worker and applicant in developing a Wellness Plan to support the wellbeing of the client and/or family system.**

APPLICATION OVERVIEW

- ☐ **This Application is to be completed and reviewed by the Referral Worker and the KFDC Intake worker.**
- ☐ **There is a clinical interview with an RTC counsellor that will need to take place before a decision is made to admit you to a program.**
- ☐ **Please ensure the medical portion (Appendix A) is completed and signed off by a physician or nurse practitioner and submitted with each application.**
- ☐ **If this is a session that allows children: All children must be up to date on immunizations to attend our facility and must submit immunization records with their applications.**

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GENERAL INFORMATION

DATE OF APPLICATION

Last Name:	**First Name:**		Alias:
Date of Birth (YYYY/MM/DD):	**Self-Identified Gender:**		**Phone #:**
			Mobile:
			Email:
Address:	**City:**	**Province:**	**Postal Code:**
Aboriginal Ancestry: ☐YES ☐NO	**Band Name:** **Band Number:**		On-Reserve: ☐ Off-Reserve: ☐
Personal Health Number:			
Emergency Contact Name:		**Emergency Contact #:**	
Emergency Contact Relationship to Client:			

EMPLOYMENT HISTORY

Source of Income:	☐Job	☐Income Assistance	☐Disability Income

Please select all that apply:

☐ Full Time
☐ Part Time
☐ Permanent
☐ Seasonal
☐ Temporary
☐ Unemployed
☐ Retired
☐ Student
☐ Self Employed
☐ Training

EDUCATION STATUS

(**Please check off ✓ the highest level of education)**

☐ Elementary (Grades 1-8)
☐ High School (Grades 9-12)
☐ Trades School (e.g. hairdressing, carpentry, etc)
☐ Adult Dogwood Certificate
☐ College/Post Secondary School
☐ University Degree (Bachelors/Masters)

Did the client graduate High School?
☐ Yes ☐ No

Applicant Initials: _____

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FAMILY RELATIONSHIPS

Current Living Arrangements

- ☐ With family
- ☐ With extended family
- ☐ With parent(s)
- ☐ With friend(s)
- ☐ Alone
- ☐ As part of a couple
- ☐ As a single parent
- ☐ With partner and kid(s)
- ☐ Recovery Home
- ☐ Shelter
- ☐ Homeless
- ☐ Other(*specify)*:

Marital Status

☐ Married ☐ Single ☐ Separated ☐ Coparenting ☐ Widowed ☐ Divorced

Dependent Child(ren) First and Last Name	**Age**	**Relationship to Applicant**	**Consent to attend treatment (*SIGNATURE REQUIRED)***

FAMILY SUPPORTS

FAMILY STRENGTHS

TREATMENT HISTORY AND NEEDS
MENTAL, EMOTIONAL, PHYSICAL, AND SPIRITUAL

How long have you maintained sobriety?

Have you participated in community-based substance use, mental health, or healing programs?
If yes, please provide treatment history:

Treatment Type	**Type of Addiction and/or Trauma Treated**	**Year**	**Complete? (Y/N)**

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Does the applicant have any special needs that the treatment centre should be aware of?
(e.g. Visual Impairments, Hearing Aids, etc.)
☐ Yes ☐ No
If yes, please provide details:

Are there any physical challenges or chronic health conditions that require special attention in any member of your family? *Please specify:*

Will the client require any assistance with reading or writing? ☐ Yes ☐ No
Additional Information:

FUNDING RESOURCES:

The following will be provided during the duration of the Rebuilding the Circle program for Status First Nations, Inuit, Metis applicants:

- Accommodations: for length of program
- Meals: Monday-Friday (Breakfast, Lunch, Dinner)

The Client is responsible for the following:

- **Meals: Weekends (Breakfast, Lunch, Dinner)**
- **Travel: To and From Program**

Contact:
intake@kackaamin.org
Our Intake Team can connect you with resources, to support the client in attending this program

- **ALL FUNDING RESOURCES MUST BE IN PLACE PRIOR TO ATTENDING**

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Healing Session Application

INFORMED CONSENT	
I, (**Client's Name, PLEASE PRINT**) _____, consent to attend KFDC and have reviewed the following points with my Referral Worker and initialed as confirmation of my understanding of the following points: ***Please initial each box below***	
1.	I consent to the Intake Coordinator contacting referral agencies, such as Medical Practitioners, Social Workers, etc. to obtain clarification on information included in this application for treatment.
2.	I understand the Intake Coordinator 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.
4.	If on provincial assistance, I agree the Intake Coordinator can release confirmation of my intake and discharge dates to my Employment and Assistance Worker.
5.	I understand the importance of being free from and have taken care of all outside business, which will take my attention away from the treatment program.
6.	I understand if I am discharged or voluntarily leave treatment, I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.
7.	I understand that if I abuse substances while in treatment it may result in my immediate dismissal from the program, with recommendations to a different "Individual" treatment program.
8.	I understand that Kackaamin staff engage in case conferencing for the benefit of treatment and healing
9.	If accepted, I consent for the Counsellor to confer with my referral worker, counsellor, social worker, or other wellness professionals if applicable, regarding my progress and clarifying any details.

Consent to Release Confidential Information

I, ***(Client Signature)*** _____ hereby give permission for KFDC staff to contact the referral worker(s) listed below for the release of information in regard to pre-treatment conference call, process during treatment, aftercare planning, and Final Discharge Report.

I, ***(Client Signature)*** _____ release KFDC from any casual liability if my personal vehicle is damaged or stolen while parked on KFDC property.

Referral Worker Name	
Alternate Worker Contact	
Organization/Agency Name	
Address	
Email	
Business Phone	
Business Fax	

X	**X**
Client Signature	**Referral Worker Signature**

****NOTE: THIS FORM IS APPLICABLE FOR ONE YEAR AFTER THE DATE SIGNED.**

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Healing Session Application
Appendix A

MEDICAL ASSESSMENT TO BE COMPLETED BY MEDICAL PERSONNEL (E.G. PHYSICIAN, NURSE PRACTITIONER, RN, LPN, COMMUNITY HEALTH NURSE, ETC.)	
PLEASE PRINT CLEARLY	
Date of Assessment/Referral:	Are you the applicant's regular medical professional? **Medical Professional Title:**
Applicant Name:	Date of Birth:
Personal Health Care Number:	Status Number:

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (applicant's name), hereby request and authorize _____ (medical professional name) to release medical information pertaining to myself to Kackaamin Family Development Centre and to my referral worker acting on my behalf (listed above).

X	**X**
Client Signature	**Medical Professional Signature**

*****Note: This form is applicable for one year after signed and dated. The Applicant may change or revoke this release at any time by giving notice to the treatment center in writing. Please complete with applicant*****

Current Medications (Names)	Dose (ml/mg)	Reason for Taking	How long has patient been taking?

1. Have you reviewed the client's medications personally?
   ☐ Yes ☐ No
2. Does the applicant take prescribed narcotics or opioid medications? ☐ Yes ☐ No
   If yes, what for, what type, and how often?
3. Does the applicant take prescribed medical marijuana in any form or oils containing CBD or THC?
   ☐ Yes ☐ No
   If yes, what for, what type, and how often
4. Is the client taking all medications as prescribed? Yes ☐ No ☐

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Healing Session Application

MEDICAL HISTORY	COMMENTS
Does the applicant have any communicable diseases? ☐ Yes ☐ No	Please specify
Has the applicant been tested for Tuberculosis? ☐ Yes ☐ No **NOTE: TB Test is REQUIRED for Admission**	Date of Test: Results: ☐ Positive ☐ Negative
Does the applicant have any head trauma or cognitive impairment? ☐ Yes ☐ No	Please specify
Does the applicant have a history of seizures? ☐ Yes ☐ No	Please specify type of seizures and date of last seizure
Does the applicant have any chronic illnesses or conditions? ☐ Yes ☐ No	Please specify
Does the applicant have any cardiovascular disorders or conditions? ☐ Yes ☐ No	Please specify
Does the applicant have any allergies? ☐ Yes ☐ No ****NOTE: clients are responsible for *their own* Epi-Pens and Ana-Kits. Kackaamin *DOES NOT* supply these****	Please specify Does applicant require an Epi-Pen or Ana-Kit? ☐ Yes ☐ No
Is the applicant pregnant? ☐ Yes ☐ No	If yes, how many weeks?
Is client currently receiving specialized medical care? (e.g. injections, dialysis, wound care, physio, chiropractor, etc.)	Please specify

Applicant Initials: _____