BEHAVIOURAL HEALTH FOUNDATION
Application for Admission

Check preference:
☐ Addiction Treatment Services ☐ Breezy Point (women's program) ☐ Either Program - first available

(To be completed by adult wanting treatment, or by referring agency worker on client's behalf)

Date: _____

Referring Agent's Name: _____
Agency: _____
Address: _____
Phone: _____
Lawyer's Name (if applicable): _____
Lawyer's Phone: _____ Email: _____

Applicant's name: _____

Address: _____

Phone: _____

Email: _____

Date of Birth (month/day/year): _____ /_____/_____ Sex: M_____F_____ Other _____
(does not identify by traditional gender definitions)

Medical # (6 digit): _____ PHIN # (9 digit): _____

Treaty Status: Yes ☐ No ☐ NIHB (Treaty #) & Band: _____

Languages: _____

Ethnic Origin: _____

Marital Status: Single _____ Married _____ Common-law _____ Separated/Divorced _____

Name of partner: _____

Will your partner attend BHF? Yes ☐ No ☐

Education: (last grade completed, further education, etc.) _____

_____

Employment History:_____

_____

_____

Children:

Please provide the following information for children currently living with you, who may reunify with you in the program or who may attend BHF for visits with you during your stay, even if there are no current plans for this in place.

Name: _____ Date of Birth (month/day/year): _____/_____/_____ Sex ____

Grade: ____ Name & Phone # of School: _____

Does this child present with any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): _____/_____/_____ Sex ____

Grade: ____ Name & Phone # of School: _____

Does this child present with any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): _____/_____/_____Sex _____

Grade: _____Name & Phone # of School: _____

Does this child present with any special needs or problems? _____

Name: _____ Date of Birth (month/day/year): _____/_____/_____Sex _____

Grade: _____ Name & Phone # of School: _____

Does this child present with any special needs or problems? _____

Please ask for an additional form if there is not enough space here for each of your children.

Current living situation for your children:

With you?: Yes ☐ No ☐ If yes, which child(ren)? _____

Other arrangement? Yes ☐ No ☐ If yes, which child(ren) and please describe. _____

_____

_____

How long have they been there? _____ How long are they expected to remain there? _____

If in CFS care, what type of order? (i.e. VPA, Permanent, Temporary, Supervision) _____

What agency are child(ren) in care of?: _____

Worker's Name: _____

Contact information: _____

If entering BHF with children, please provide the most current school report card for each child prior to entry.

Next of Kin in Case of Emergency:

Name: _____ Relationship to you: _____

Address: _____

Phone #: _____ Email: _____

Presenting Problem: (check all that are applicable to you)

Alcohol ___ Solvents ___ Drugs ___ List: _____

Other ___ List: _____

Applicant's health: (i.e. allergies, physical or cognitive disabilities, general state)

_____

_____

_____

Are you pregnant? Yes ☐ No ☐ If yes, estimated due date: _____

Are you on any prescribed medication? Yes ☐ No ☐ If yes, list: _____

_____

Doctor Name and Contact Info: _____

Have you ever experienced any of the following:

Major Depression	Yes	☐	No	☐	
Bi-Polar	Yes	☐	No	☐	
Major Anxiety	Yes	☐	No	☐	
Psychosis	Yes	☐	No	☐	
Schizophrenia	Yes	☐	No	☐	
ADHD	Yes	☐	No	☐	
PTSD	Yes	☐	No	☐	
Other Mental Health Concern	Yes	☐	No	☐	Please provide information. _____

_____

Are you currently experiencing suicidal ideation? Yes ☐ No ☐

Have you ever been given a mental health diagnosis by a qualified health professional? Yes ☐ No ☐

If yes, list diagnosis and name and location of professional: _____

_____

_____

When were you diagnosed? _____

Have you ever been hospitalized for a mental health related illness? Yes ☐ No ☐

If yes, when, where and for which illness? _____

Have you ever harmed yourself or thought of harming yourself, but not as a direct result of alcohol or other drug use? Yes ☐ No ☐

If yes, list all incidents. _____

_____

Have you ever suffered any significant trauma? Yes ☐ No ☐

Please provide a brief description of problems that are occurring within your family unit. Include any issues related to family violence and past or present domestic assault charges.

_____

_____

Please describe your current housing or shelter situation:

_____

_____

Previous involvement in addiction and/or mental health treatment facilities:

Have you attended BHF in the past? Yes ☐ No ☐

Name of other Treatment Facility: _____

Approximate Date: _____

Involvement with the Justice System:

Previous Criminal Record: _____

_____

Are you facing any criminal charges? Yes ☐ No ☐

If yes, list and provide a copy of current conditions: _____

_____

_____

Have you ever been charged with sexual assault or other sexual offences? Yes ☐ No ☐

If yes, explain:_____

_____

Have you ever been charged with arson/setting fires? Yes ☐ No ☐

If yes, explain: _____

_____

Have you ever been charged with any crimes against children? Yes ☐ No ☐

If yes, explain: _____

_____

Are you on probation? Yes ☐ No ☐

If yes, give name and address of Probation Officer: _____

_____

Financial Information

Do you have a bank account? Yes ☐ No ☐

Are you presently funded by Employment and Income Assistance? Yes ☐ No ☐

Province of Manitoba _____ Other Program _____ EIA # _____

BHF provides services through funding agreements with government departments for Manitobans who do not have the ability to pay the full cost for addiction treatment services. However, program participants are required to pay monthly room and board rates as well as for any unfunded medication. BHF's Intake Worker assists in providing detailed information regarding funding/fees. The first month's room and board fees are due at entry.

Out of province referrals are required to pay per diem rates.

Funding Source: _____
Address: _____
Phone#: _____

For out of Country Referrals Only:

Do you carry private health care insurance? Yes ☐ No ☐

If yes, what is the name of the health care provider and policy name and number?

_____

If no, is the referral agency prepared to cover health care costs that may be incurred during the treatment stay?
Yes ☐ No ☐

FOR BEHAVIOURAL HEALTH FOUNDATION USE ONLY

Is referral suitable for placement? Yes _____ No _____

If not suitable, document reason: _____

Were recommendations for alternative services made? Yes _____ No _____

If yes, what were they? _____

Follow up info:

_____

_____

Staff signature: _____

Please email, mail or fax this form to:

TO BE COMPLETED BY PERSON SEEKING TREATMENT

1. I understand that I am required to have my doctor complete a "Medical Clearance for Treatment" form prior to entering the BHF program. I understand that the Medical and Medication information provided on this form, must be consistent with the Medical Clearance form or it will delay my entry into BHF treatment.
2. I understand that upon entry to BHF, if I am on prescribed medication, I am to bring either a current prescription and a method of payment, or a minimum 2 to 4 week supply of all medications. If I do not do either, I will be without medication during my initial stay.
3. I hereby provide consent to BHF staff to discuss my Application for Admission and program suitability with the Referring Agent and/or Lawyer named on page 1 of this Application.

I agree to undergo treatment at the Behavioural Health Foundation and have read numbers 1-3 above and believe all of the information in this Application for Admission is correct and true.

_____ _____

Applicant's signature Date

I understand that if I am a suitable candidate for the BHF program, I can name a supportive family member/support person who may be called upon during my treatment stay to assist as necessary. I also understand that it is acceptable not to involve a support person in my treatment if I choose.

Choose one option (a) or (b):

BHF has my consent to contact the following person for the purpose of supporting me throughout my treatment stay. I may revoke this consent at any time by indicating that in writing to my Keyworker.

a) Name: _____Relationship to me: _____

Address: _____ _

Phone: _____ Email: _____

BHF has my consent to contact this person following my departure from treatment within 72 hours when consent expires. Yes _____ No _____

b) I do not wish to have an external support person during my treatment stay.

Signed: _____ Date: _____

Addiction Treatment Services
Box 250, 35 ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 269-8049
Phone: (204) 269-3430 Ext: 140
Email: atsintake@bhf.ca

OR

Breezy Point (women's program)
Box 250, 35B ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 275-2099
Phone: (204) 261-6111 (Intake)
Email: bpintake@bhf.ca