CHARIS CENTRE

tel: 204-415-3934 ext. 514 fax: 1-888-693-3468
email: ugm.womens.intake@gospelmission.ca

Application for Residency of Union Gospel Mission's Women's Addictions Recovery Program

Date of Application: _____

Applicant's Name: _____ D.O.B._____ (month/day/year)

Marital/Relationship Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Common –Law ❑ Other

Phone number(s) where you can be reached. 1) (_____) _____ 2) (____) _____
3) Cell#: _____

Current address: _____
Renting: ❑ Yes EIA: ___ Private: ____ ❑ No

Contact person: Name: _____ Relationship to you: _____

Phone #: (_____) _____

Have you previously filled out an application form for entering Charis Centre? ❑ Yes ❑ No

If yes, approx. date of application: _____

Have you been admitted to Charis Centre before? ❑ Yes ❑ No if yes, date of residence at CC: _____

Recovery Chaplain Name: _____

Referred to Charis Centre by: _____ (self, agency, friend, etc.)

Contact's phone number: _____

Do you have relatives/friends currently (or past) residing at Charis Centre? If so, who?

_____

Why do you want to live and participate in the Charis Centre Recovery Program?

_____

What would you like to accomplish during your stay at the Charis Centre?
B.R.E.A.T.H (minimum of 45 days) _____ HEART (long term) ❑ Yes ❑ No ❑ Undecided

_____

Do you agree to participate in a Biblically-based recovery program? ❑ Yes ❑ No

Church affiliation, if any? _____ List any previous involvement: _____

Community Supports

Are you currently supported by any community agencies or mental health organizations? ❑ Yes ❑ No

If yes, please specifiy:_____

Health

Do you have any specific health problems? ❑ Yes ❑ No If yes, please explain.

_____

Date of last physical completed: _____ Date of last dental exam: _____ (can be approx.)

Do you have any immediate medical needs? ❑ Yes ❑ No i.e. Surgery, physiotherapy, chiropractic, allergies (epi pen) etc.

List Medical Appointments:

_____

Do you have any immediate medication needs? ❑ Yes ❑ No

***List all medications you are currently taking on the sheet provided at the back of the application form.**

Are you pregnant? ❑ Yes ❑ No ❑ Maybe If yes, what is your due date? _____

Are there any specific concerns in regards to your pregnancy? ❑ Yes ❑ No If yes, please explain.

_____

Mental Health

Do you experience any mental health issues? ❑ Yes ❑ No Diagnosed ❑ Yes ❑ No

Specify: _____ Schizophrenia: ❑ Yes ❑ No Depression ❑ Yes ❑ No Anxiety ❑ Yes ❑ No

❑ Eating disorders? Current: yes / no Past: yes / no Explain:

_____

Have you ever attempted suicide? ❑ Yes ❑ No If yes, date of last attempt: _____
Explain:

_____

Hospitalized for suicide attempt ❑ Yes ❑ No

Psychiatrist _____Psychologist or Mental Health Worker_____

Phone #: _____

If yes, where did or do you receive treatment? _____ Date of last appointment:_____

M.H.S.C. (6 digit registration #) _____ (9 digit I.D. #) _____

Family Doctor's Name: _____ Phone #: _____

Clinic: _____

We require residents to do daily chores. Can you participate in the chore system? ❑ Yes ❑ No

Any Limitations? _____

**Please note, failure to comply with chore requirements as arranged could result in exiting the program.*

Abuse

Have you been sexually abused? ❑ Yes ❑ No In childhood ❑ Yes ❑ No In adulthood ❑ Yes ❑ No
Treatment ❑ Yes ❑ No

Have you ever been in an abusive relationship? ❑ Yes ❑ No If yes, describe the abuse: ❑ physical ❑ emotional

_____

Name: _____ Relationship: _____

Current restraining Order: ❑ Yes ❑ No If yes, explain (name and terms): _____

Date order was issued: _____

Addiction History

Do you use: Alcohol? ❑ Yes ❑ No Frequency of use: ❑ Daily ❑ Binge How long: _____

Last drink: _____ Longest period of sobriety: _____

Substances? ❑ Yes ❑ No what is your drug of choice: _____ How long have you used? _____

Last use: _____ Longest period of being clean: _____

Previous drug use? ❑ Yes ❑ No List substances: _____ _____

Do you smoke? ❑ Yes ❑ No Gambling? ❑ Yes ❑ No How long have you been gambling? _____

Have you every completed a drug or alcohol treatment program? ❑ Yes ❑ No When? _____

Where? _____

Charis Centre is a drug/alcohol free environment. We will do random drug/alcohol testing. We do not allow residents to use any type of alcohol or substance. It is your responsibility to remain clean and sober while you reside at the Charis Centre. Failure to do so may result in exiting the program immediately.

Can you comply with these rules? ❑ Yes ❑ No

Payment for treatment (room and board, courses, counselling)

Source of Income: ❑ EIA - yes / no / pending ❑ Disability - yes / no / pending ❑ Private ❑ Band ❑ Other

_____

EIA #: _____ Direct Deposit ❑ Yes ❑ No EIA Worker's: Name/Ph. #/Address:

_____

Upcoming EIA Appointment? ❑ Yes ❑ No If yes, Date/Time: _____

Other

Have you ever been convicted of: criminal charges? ❑ Yes ❑ No

Arson: ❑ Yes ❑ No Sexual Offence: ❑ Yes ❑ No Murder: ❑ Yes ❑ No

Dates and offenses of criminal record:

_____

Current Criminal Charges: ❑ Yes ❑ No Explain:

_____

Are you on: Bail ❑ Yes ❑ No Probation ❑ Yes ❑ No

Name/Phone #/Address of P.O.: _____

Name/Phone # of lawyer: _____ List all upcoming court dates/appointments with P.O., lawyer, etc. (Include a brief explanation of each)

_____

Highest Education Level Achieved: _____

Height _____ Weight _____ Eyes (Colour) _____ Hair (Colour) _____ Glasses Required: ❑ Yes ❑ No

Treaty Status? ❑ Yes ❑ No Band Name: _____ Treaty #_____

Scars: _____

Tattoos: _____

_____

_____

Children

If applicable, name, birth date, age, current custody arrangement of your children under 18 years old.

First & Last Name	Gender	Birth Dates	Age	Current Custody Arrangement i.e. Temp/VPA/Permanent

CFS Worker: Name: _____ Phone number: _____

Agency Name and Contact Information: _____

Upcoming CFS Court Dates: _____

CFS Lawyer Name/Phone: _____

Medication

Use this space to list all medication you are currently taking:

Medication Name	Purpose	Dosage Amounts/Frequency Taken

Are you on any of the following opioid replacement treatments: Suboxone, Methadone, or Sublocade? If yes, please

specify:_____

I _____ (print name) verify that all the facts in this application accurately reflect my present situation.

I understand that **failure to disclose all pertinent information or falsification of information** given in the application may result in my immediate exit from the Charis Centre program.

_____ (Signature of Applicant)