BEHAVIOURAL HEALTH FOUNDATON
Application for Admission
Men's, Women's & Family Addictions and Co-occurring Mental Health Treatment Services (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: _____ Phone: _____
(if applicable)

Applicant's name: _____

Address: _____

Phone: _____

Date of Birth (month/day/year): _____ / _____/ _____ Sex: M_____ F_____

Medical #: _____ Treaty # & Band: _____

S.I.N. #/Security #: _____ Languages: _____

Ethnic Origin: _____

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

If married, name of spouse: _____

List Children: (if entering BHF with children, please provide the most current school report card for each child prior to entry)

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

Grade: ____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

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

Grade: ____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

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

Grade: ____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

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

Grade: ____ Name & Phone # of School: _____

Does this child present any special needs or problems? _____

Are child(ren) in care of a child care agency: Yes ☐ No ☐

If yes, which child(ren)? _____

How long have they been in care? _____ How long are they expected to stay in care? _____

What type of order is in place? (i.e. VPA, Permanent, Temporary, Supervision) _____

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

Worker's Name: _____

Address: _____

Next of Kin in Case of Emergency:

Name: _____

Address: _____

Phone #: _____ Relationship to you: _____

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

Alcohol ___ Solvents ___ Drugs ___ (Please specify) _____

Other ___ (Please specify) _____

Applicant's health: (i.e. allergies, physically or mentally disabled, general state)

_____

_____

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

_____

Have you been diagnosed, or ever experienced any of the following:

Major Depression	Yes ☐ No ☐	Schizophrenia	Yes ☐ No ☐
Bi-Polar	Yes ☐ No ☐	Other Mental Health	Yes ☐ No ☐
Major Anxiety Disorder	Yes ☐ No ☐		

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 detailed 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 homelessness situation:

_____

_____

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

Name of Facility: _____

Approximate Date: _____

Work Experience: _____

_____

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

_____

Previous Criminal Record: _____

_____

Are you facing any criminal charges? Yes ☐ No ☐

If yes, list: _____

_____

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: _____

_____

Please provide a Social History if available. Send with the completed application form.

Do you have a bank account? Yes ☐ No ☐

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

BHF provides services through funding agreements with government departments for Manitobans who do not have the ability to pay for addiction treatment services. Persons who have a source of income, ie: employment, employment insurance, pension or disability benefits, etc., are required to pay a monthly room and board rate. Out of province referrals are required to pay per day rates. BHF's Intake Worker assists in providing detailed information regarding funding/fees upon request.

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 ☐

TO BE COMPLETED BY PERSON SEEKING TREATMENT

1. I understand that upon entry to BHF I am to bring either a current prescription and a method of payment, or a minimum 2 week supply of all medications, otherwise I will be without medication during my initial stay.
2. 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:

   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.

   Name: _____ Relationship to me: _____

   Best way to contact: Address: _____

   Phone: _____ Email: _____

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

   Signed: _____ Date: _____
3. I agree to undergo treatment at the Behavioural Health Foundation and believe all of the information in this referral is correct.

   _____ _____

   Applicant's signature Date

Please mail or fax this form to:
Behavioural Health Foundation
Box 250, 35 ave de la Digue
St. Norbert, MB R3V 1L6
Fax: (204) 269-8049
Phone: (204) 269-3430

FOR BEHAVIOURAL HEALTH FOUNDATION USE ONLY

Is referral suitable for placement? Yes _____ No _____

If unacceptable, document reason: _____

Were recommendations for alternative services made? Yes _____ No _____

If yes, what were they? _____

Follow up info:

_____

_____

Staff signature: _____