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 ☐ NHIB (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