Treatment Centre Adult Referral Application Package



First Nations Health Authority
Health through wellness

Updated: October 2026

Inclusion Criteria

Inclusion	Carrier Sekani Family Services	Gya' Wa' Tlaab Healing Centre	Kackaamin	'Namgis Treatment Centre	North Wind Wellness Centre	Round Lake Treatment Centre	Tsow-Tun Le Lum Society	Wilp Si'Satxw Community Healing Centre [5]
Opioid Agonist Therapy	✓	✓	✓ [4]		✓	✓		✓
Family Program			✓					✓
Couples Program								✓
Pregnant	✓				✓	✓	✓	✓
Co-ed	✓		✓		✓	✓	✓	✓
Men-only sessions		✓	✓	✓				✓
Women-only sessions			✓	✓				✓
Corrections Program					✓		✓	✓
Barrier Free (person with ability challenges)			Case-by-case			✓	✓	✓
Other Substance-free	14 Days	Minor with-drawal	3 Weeks	14 Days	14 Days	14 Days	14 Days [1]	14 Days
Requires signed Rules and Regulations with Application [2]			✓ [3]		✓			✓ [6]

Endnotes

1 Limited stabilization beds available on-site; arrangements must be made prior to admission.
2 RLTC requires applicants to be 5 months free of Crystal Meth in order to attend their programs.
3 Website: kackaamin.org
4 Sublocade only at their Core/Family Program
5 Call to inquire about program-specic corhots
6 Website: https://www.wilpchc.ca/

Treatment Centre Descriptions

	Carrier Sekani Family Services P.O. Box 1219 Vanderhoof, B.C. V0G 2A0 https://www.csfs.org/programs/substance-use-recovery-program/ Telephone: (250) 567-2900 Toll-free: 1-866-567-2333 Fax: (250) 567-2975	Length: 5 weeks OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes (2nd Tri.) Substance free: 14 days Residential Treatment Program only April - October
	Gya'Wa'Tlaab Healing Centre P.O. Box 1018 Haisla, B.C. V0T 2B0 gyawatlaab.ca Telephone: (250) 639-9817 Fax: (250) 639-9815	Length: 6/7/8 weeks OAT: Yes Family Program: No Couples Program: No Gender: Men-only Pregnant: N/A Substance Free: Minor Withdrawal
	Kackaamin 7830 Beaver Creek Road Port Alberni, B.C. V9Y 8N3 kackaamin.org Telephone: (250) 723-7789 Fax : 250-723-5926	Length: 6 weeks OAT: Sublocade only Family Program: Yes Couples Program: No Gender: Co-ed, Men- & Women-only Pregnant: No Substance Free: 3 weeks See website for all applications
	'Namgis Treatment Centre P.O. Box 290 Alert Bay, B.C. V0N 1A0 http://www.namgis.bc.ca/health- services/treatment-centre Telephone: (250) 974-5522 Fax: (250) 974-2257	Length: 6 weeks OAT: No Family Program: No Couples Program: No Gender: Women- & Men-only Pregnant: No Substance Free: 14 days
	Nenqayni Wellness Centre nenqayni.com	Outreach/Community-based

Treatment Centre Descriptions

	North Wind Wellness Centre Mailing Address Box 2480 Station A Dawson Creek, BC V1G 4T9 Physical Address 5524 235 Rd Farmington, BC V0C 1N0 northwindwellnesscentre.ca Telephone: (250) 843-6977 Fax: (250) 843-6978	Length: 42 days, 6 weeks OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes Substance free: 14 days See website to download and submit signed rules and regulations
	Round Lake Treatment Centre 200 Emery Louis Road Armstrong, B.C. V0E 1B5 roundlaketreatmentcentre.ca Telephone: (250) 546-3077 Fax: (250) 546-3227	Length: 6-week OAT: Yes Family Program: No Couples Program: No Gender: Co-ed Pregnant: Yes (2nd Tri.) Substance free: 14 days (Crystal Meth: 5 months)
	Telmexw Awtexw Treatment Centre Mailing Address 4690 Salish Way Agassiz, B.C. V0M 1A1 Physical Address 16300 Morris Valley Rd Agassiz, B.C. V0M 1A1 stsailes.com/telmexw-awtexw Telephone: (604) 796-9829 Fax: (604) 796-9839	Outpatient/Community-based
	Tsow-Tun Le Lum Society Mailing Address: PO Box 308 Stn Main Physical Address: 2850 Miller Rd Duncan B.C. V9L 3X5 tsowtunlelum.org Telephone: (250) 390-3123 Fax: (250) 390-3119	Thuy Na Mut (A&D) Program Length: 40-day OAT: No Family Program: No Couples Program: No No Gender: Co-ed Pregnant: Yes (up to 3rd trimester) Substance free: 14 days See website for information on how to apply to the Kwunatsustul Program (Trauma/Grief/Codependency)
	Wilp Si'Satxw Community Healing Centre Box 429 Cedarvale-Kitwanga Road Kitwanga, B.C. V0J 2A0 wilpchc.ca Telephone: (250) 849-5211 Fax: (250) 849-5374	Length: 42-day, 2 eight- week programs OAT: Yes Family Program: Yes Couples Program: Yes Gender: Co-ed, Men- & Women-only Pregnant: Yes (2nd Tri.) Substance free: 14 days

Treatment Centre Adult Referral Application Package

Package Completion Process and Check List

Please note:

This package is intended to be completed by a community support team member and a medical professional in collaboration with the applicant.

Applications **(pages 5-15 only)** should be submitted **directly to the identified Treatment and Healing Centre(s)** for processing. To avoid delays, please ensure the following requirements have been completed prior to submission.

- ☐ Review the FNHA-Funded Treatment Centre Descriptions and inclusion criteria.
- ☐ Identify the Treatment and Healing Centre(s) the applicant is applying to and the specific program if applicable (Section 1, Page 5)
- ☐ Complete the included referral package

Blue Sections (Pages 5 - 10)

To be completed by a referral worker and client.

- ☐ Consent for Release of Treatment Information (Page 5)
- ☐ Referral Worker Information (Page 6)
- ☐ Applicant's Personal Information (Page 6)
- ☐ Income and Education (Page 7)
- ☐ Legal Assessment (Page 7)
- ☐ Family and Living Arrangements (Page 8)
- ☐ Wellness (Page 8)
- ☐ Substance Use History (Page 9)
- ☐ Treatment History (Page 10)
- ☐ Additional Information (Page 10)

Red Sections (Pages 11 - 13)

To be completed by a medical professional.

Note: *Medical Professional can be: (e.g., Physician, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse)*

- ☐ Medical Assessment (Page 11)
- ☐ Tuberculosis (TB) Screening (Page 13)
- ☐ Tuberculosis (TB) Clearance (Page 14)

Green Section (Page 15)

To be completed by a referral worker in collaboration with the applicant. Only to be completed if applicants are applying to the following Treatment and Healing Centres.

- ☐ Appendix A (Page 15)

- Round Lake Treatment Centre
- Tsow-Tun Le Lum Society
- Kackaamin Family Development Centre
- North Wind Wellness Centre
- Wilp Si' Satxw Community Healing Centre
- Gya'Wa'Tlaab Healing Centre
- Carrier Sekani Family Services

Include the following collateral information if available and applicable:

- ☐ Document to show mandate to attend Treatment
- ☐ Parole/Probation/Release/Undertaking Order(s)
- ☐ Mental Health Assessment
- ☐ Tuberculosis Test Results/Chest X-Rays (if applicable)

If applying to family program at Kackaamin and/or Carrier Sekani Family Services, please visit their websites for the applicable applications for dependents and families.

In consultation with the applicant, please complete the participatory agreements found at the specific Treatment and Healing Centre Websites, if applicable to where the applicant is applying to (identified in Inclusion Criteria, Page 1).

Part 1: Employee/Vendor Information

Please identify your top choices (1 being top choice) for Treatment Centres you are applying to.

	Treatment Centre Name	Specific Program (if applicable)

Section 2: Consent for Release of Treatment Information

Release of confidential information between treatment centre staff and other organization or agencies.

I _____ (print applicant's name), hereby give permission for the identified Treatment Centre staff to contact the identified individuals listed below for the release of information, including electronic records, in regard to pre-treatment information, attendance verification, progress during treatment, aftercare planning, final discharge report, and/or emergency situations. By using this form, I also understand that I am providing my consent for the intake workers at the Treatment Centres listed on pages 2 and 3 of this document to discuss the information, including electronic records, within this application package to support the referral process and ensure the most appropriate treatment plan is established.

_____ **Referral Worker or Assigned Agency Alternate**	_____ **Organization**	**Phone:** _____ **Email:** _____ **Fax:** _____	☐ Pre-Treatment Information ☐ Attendance Verification ☐ Progress during Treatment ☐ Aftercare Planning ☐ Final Discharge Report
_____ **Individual #2 E.g. Probation Officer**	_____ **Organization**	**Phone:** _____ **Email:** _____ **Fax:** _____	☐ Pre-Treatment Information ☐ Attendance Verification ☐ Progress during Treatment ☐ Aftercare Planning ☐ Final Discharge Report
_____ **Emergency Contact**	_____ **Relationship to Applicant**	**Phone:** _____ **Email:** _____ **Fax:** _____	☐ Attendance Verification ☐ Aftercare Planning ☐ Emergency Situation ☐ Can be contacted after hours
_____ **Emergency Contact**	_____ **Relationship to Applicant**	**Phone:** _____ **Email:** _____ **Fax:** _____	☐ Attendance Verification ☐ Aftercare Planning ☐ Emergency Situation ☐ Can be contacted after hours

Applicant Signature:	*Date:*
Referral Worker's Signature:	*Date:*

Note: *This Consent to Release Information form is valid for one year from the date it is signed and dated. The applicant may revoke or change this consent at any time by providing written notice to the Treatment Centre.*

Section 3: Referral Worker Information

Date of Assessment/Referral:	Referral Worker Name:	Title/Position:
Organization/Agency Name:	Email:	Referral Worker's Phone Number:
Address:	City, Province:	Postal Code:

Is the applicant receiving supports and resources from you? ◯ Yes ◯ No

Are there supportive services available to applicant upon discharge? ◯ Yes ◯ No

Has the applicant accessed any cultural, community, peer or clinical supports? (e.g., AA, NA, Counselling, etc.)?

◯ Yes ◯ No

If yes, please explain what type of support and how many sessions have been completed:

Where does the applicant go in their community for support?

Section 4: Personal Information

4.1 Basic Information sonal Information

Last Name:	First Name: Middle Name:	Preferred Name:
Birthdate (DD/MM/YYYY)	Telephone	Cellphone (if applicable):
Current Address:	City, Province:	Postal Code:
◯ In-Community ◯ Off-Reserve	Email:	

Self-Identified Gender (select all that apply):

☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Questioning ☐ My Gender is:_____

Self-Identified Gender (select all that apply):

☐ He ☐ She ☐ They ☐ Pronouns are: _____

If you identify as transgender, non-binary, or Two-Spirit, please inform us what residential space the applicant would prefer to stay within: ☐ Male ☐ Female

Indigenous Identity: ◯ Status ◯ Non-Status ◯ Métis ◯ Inuit ◯ N/A

Status Number (if applicable):	Band Name (if applicable):	Treaty Community (if applicable):
Personal Health Number:	Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

Has applicant been legally required to participate in treatment as part of a court order or other legal process? ◯ Yes ◯ No

If yes, by whom? _____

Must attach any applicable documents.

4.2 Funding Resources

Have funding options been explored? ◯ Yes ◯ No *Note: Funding resources must be in place prior to attending.*
If yes, provide details (e.g. FNHA, First Nations Band, Employer, Corrections, SDPR):

Does the applicant have funding for travel to and from treatment? ◯ Yes ◯ No

Have travel arrangements been arranged? ◯ Yes ◯ No

Section 5: Income and Education

Source of income (employed, social assistance, disability, etc.)?

Self-Identified Gender (select all that apply):
☐ Employed full-time ☐ Employed part-time ☐ Seasonal worker ☐ Primary care-taker of children and/or home
☐ Student ☐ Retired ☐ Unemployed ☐ Other (specify): _____

What level of literacy is the applicant at? ◯ Low ◯ Medium ◯ High

Does the applicant require any reading supports?	Does the applicant require any writing supports?
◯ Yes ◯ No	◯ Yes ◯ No

If yes to either or both of the above, please explain what additional supports would be required to support the applicant:

Section 6: Legal

Does the applicant have a history with the legal system? ◯ Yes ◯ No
If yes, please complete this section in full. If no, please move to next section.

Does the applicant have any previous convictions/charges/legal involvement? ◯ Yes ◯ No
If yes, describe:

If yes, were charges (select all that apply):
☐ Violent ☐ Sexual ☐ Substance Related ☐ Involved a minor ☐ Involved a partner

Does the applicant have any current and/or pending legal orders or legal involvement? ◯ Yes ◯ No
If yes, describe:

If yes, were charges (select all that apply):
☐ Violent ☐ Sexual ☐ Substance Related ☐ Involved a minor ☐ Involved a partner

List any upcoming or pending court dates:

Is the applicant currently:
☐ On Parole ☐ Serving a Probation Order ☐ Bound by Release Order/Undertaking (Bail Order)
If you selected any of the above, any applicable documents and orders must be attached.

If yes to either of the above, please provide the following information and include the Parole/Probation/Bail Officer in Section 2: Consent for Release of Treatment Information:
Parole/Probation/Bail Officer Name: P/P/B Officer Telephone: P/P/B Officer Email:

Address: City, Province: Postal Code:

Please attach any applicable legal documentation

Section 7: Family and Living Arrangements

Note: if the applicant is applying to family program at **Kackaamin** and/or **Carrier Sekani Family Services**, please visit their websites for the applicable applications for dependents and families.

Total number of dependent children: _____

Have children been living with their parent(s)? ◯ Yes ◯ No

If no, who do they live with?

Have children been apprehended, placed in foster care, or with a Designated Aboriginal Agency? ◯ Yes ◯ No

If yes, specify by which organization or agency:

Does the family have any type of supervision order from a family protection agency? ◯ Yes ◯ No

Does the applicant have any outstanding child custody issues? ◯ Yes ◯ No

Does the applicant have a no-contact order with his/her partner? ◯ Yes ◯ No

What is the applicant's current living arrangements?

☐ With my family ☐ With extended family ☐ With parent(s) ☐ With friend(s) ☐ As part of a couple

☐ A single parent ☐ With partner and kid(s) ☐ Alone ☐ Recovery Home ☐ Unhoused ☐ Shelter

☐ Other (specify): _____

Section 8: Wellness

Has the applicant been impacted by systemic, trauma-related histories and/or experiences (e.g., Indian Residential School, Day School, extended hospitalization, 60s Scoop, foster care, intergenerational survivor etc.)? ◯ Yes ◯ No

If yes, and you feel safe to do so, please provide further information:

Has the applicant ever disclosed engaging in behaviors that caused sexual harm to another person or crossed sexual boundaries? ◯ Yes ◯ No

8.1: Mental

Does the applicant have a history of or have they ever been diagnosed with a mental health condition, disability or challenge by a medical professional? ◯ Yes ◯ No

If yes, please attach assessment if available and select all that apply:

☐ Depression ☐ Anxiety/Panic Disorders ☐ Brain/Head Injury ☐ ADHD ☐ FAS/FAE ☐ PTSD

☐ Military/First Responder PTSD ☐ Other (specify): _____

Does the applicant have a history of: ☐ Suicidal Ideation ☐ Self-Harm

Has the applicant had a suicide attempt? ◯ Yes ◯ No If yes, when was last attempt? _____

Has the applicant ever been under a Doctor's care due to mental health condition, disability or challenge? ◯ Yes ◯ No

8.2: Physical

Does the applicant have any chronic or acute medical issues that could affect their participation in the program?

◯ Yes ◯ No

Does the applicant have any ability challenges that the treatment centre should be aware of (e.g. visual impairments, hearing aids, mobility, etc.)? ◯ Yes ◯ No

If yes, please describe what ability support the applicant would require:

8.3: Spiritual

Please share the applicant's current or desired spiritual and cultural involvement in their healing journey.

Is the applicant willing to respect First Nations healing practices and incorporate spirituality into their healing (e.g. Sweat Lodge, Cedar Brushing, Pipe Ceremony, Smudge, etc.)? ◯ Yes ◯ No

Section 9: Substance Use History

Please identify the primary substance(s) of concern.

Substance/ Behavior	Estimated Age of First Use	How Often (rarely, occasionally, monthly, weekly, daily)	Amount/Quantity Used	Date of Last Use (Day/Month/Year)
Alcohol				
Amphetamines				
Cannabis				
Cannabis - Medical				
Cocaine (Crack or Powder)				
Crystal Meth				
Hallucinogens				
Inhalants				
Prescription Medications (Used Non-Medically)				
Opioids				
Process addiction (e.g. gambling, eating):				
Tobacco				
Vaping				
Other (specify):				

Section 10: Treatment History

Has the applicant attended inpatient substance use treatment before? ○ Yes ○ No

If yes, please fill in the following:

Name of previous treatment centre(s)	Date	Did he/she/they complete program?
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No

Has the applicant participated in outpatient or community-based healing programs? ○ Yes ○ No

If yes, please explain:

Section 11: Additional Information

In case of early dismissal or incompletion of the program, does the applicant have a plan in place? ○ Yes ○ No

If yes, please share your early exit plans below. If no, please work with the applicant to establish one.

Is the applicant currently receiving specialized medical care? (e.g., injections, dialysis, physiotherapy, chiropractor, etc.)

Beyond the scope of this application, do you have any additional comments or information that the intake staff should be aware of?

Section 12: Medical Assessment

To be completed by medical personnel (e.g., Physician, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse)

Date of Assessment/Referral:	Are you the applicant's regular Physician/Nurse?
Applicant's Name:	Date of Birth (DD/MM/YYY):
Personal Health Care Number:	Status Number (if applicable):

I _____(applicant's name), hereby request and authorize _____ (Physician, Nurse Practitioner or Registered Nurse's name) to release medical information pertaining to myself to the identified First Nations Health Authority Funded Treatment Centres (under Section 1) and to the Referral Agent acting on my behalf.

_____ _____
Applicant's Signature Date

_____ _____
Medical Personnel's Signature Date

_____
Medical Personnel's Position/Title

Informed consent must be completed with the Patient.

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 Centre in writing.

Specify any dietary requirements (allergies, intolerances, diabetes, etc.):

Current medications (Names)	Dose (ml/mg)	Reason for taking	How long has applicant been taking?	Prescriber	Has refills?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

Is applicant currently on Opioid Agonist Therapy (OAT)? ◯ Yes ◯ No

If yes, please complete the following information.

OAT Prescribing Physician/Nurse Practitioner:

Name: Telephone: Fax:

Address: City, Province: Postal Code:

Specify Replacement Type (e.g. Methadone, Suboxone, etc.):	Initial dose (mg): Current dose (mg):
Length of OAT:	Length of time on current dose:

Note: If you are applying to Round Lake Treatment Centre, please refer to and complete **Methadone & Suboxone Program Contract.** If you are applying to Wilp Si'Satxw, please refer to and complete **Methadone & Suboxone Contract.**

Have you reviewed the prescribed medication with the applicant? ◯ Yes ◯ No	
Is the applicant taking their medication as prescribed? ◯ Yes ◯ No	

Medical History	Comments
Does the applicant have any communicable diseases? ◯ Yes ◯ No	
Does the applicant have any head trauma or cognitive impairment? ◯ Yes ◯ No	
Does the applicant have a history of seizures? ◯ Yes ◯ No	
Does the applicant have any chronic illnesses or conditions? ◯ Yes ◯ No	
Does the applicant have any cardiovascular disorders or conditions? ◯ Yes ◯ No	
Does the applicant have any allergies? ◯ Yes ◯ No	Does applicant require an Epi-Pen or Ana-Kit? ◯ Yes ◯ No **Note:** Applicant is required to supply their own Epi-Pen or Ana-Kit
Is the applicant pregnant? ◯ Yes ◯ No ◯ N/A	If yes, how many weeks? _____

Section 13: Tuberculosis (TB) Screening

To be completed by medical personnel (e.g., Physician, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse)

The purpose of TB screening for entry into treatment programs is to **rule out active TB.**

TB skin testing (TST) or a chest x-ray (CXR) **is not required** for entry into treatment. However, a TST or CXR (if indicated) should be offered if there is adequate time beforehand and would not delay entry into the treatment facility.

People who use substances are an important group to consider for follow-up. Discuss with client a TB screening plan when the person returns from treatment.

A. TB Symptom Assessment		
☐ None	☐ Fever	☐ Short of Breath
☐ Chest pain	☐ Haemoptysis	☐ Sputum Production
☐ Cough (for >3weeks)	☐ Lymphadenopathy	☐ Unintentional Weight Loss
☐ Fatigue	☐ Drenching Night Sweats	☐ Other:

*** If client has a cough, or other symptoms consistent with active TB, collect 3 sputum for AFB, switch to the BCCDC TB Screening Form to fill out and fax to appropriate TB Services program.**

For clients who live in a First Nations community fax form to FNHA TB Services at 604-689-3302.

For clients who live outside of community fax form to BCCDC at 604-707-2690 or Island TB Services at 250-519-1505

TB Screening Form:

http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/TB/CPS_TB_ScreeningForm.pdf

B. TB History (check all that apply)
☐ Has the client ever had a positive TST and/ or IGRA result?
☐ Has the client ever been in contact with someone with active TB?
☐ Has the client ever been treated for TB?
Please gather most current TB history from client chart, panorama, or reach out to FNHA TB Services at 1-844-364-2232

Please ensure that you document this information in the client's file as per your organization's policy.

C. TB Risk Factors (Check all that apply)	
Certain risk factors pose a higher risk for progression to active TB in the presence of TB infection or increase the risk of exposure to TB.	
☐ None	
☐ HIV	☐ Substance Use (Specify)
☐ Transplant (Specify):	☐ Tobacco Use
☐ Diabetes	☐ Work or live in a congregate setting (past or current)
☐ Cancer (Specify):	☐ Work or live in a Correctional Facility (past or current)
☐ Chronic Kidney Disease/Dialysis	☐ Unhoused (past or current)
☐ Immune Suppressing Meds (name, dose & duration)	

***NOTE TO PRACTITIONER:** Some people may benefit from further TB-related follow-up care such as a TB skin test or TB Preventive Therapy. For those with TB history and/or risk factors, consider discussing a plan to connect with the client again once they are back in the community.

D. Clearance Notice

***Health Practitioner please submit this TB Clearance Notice to the treatment center for clearance of individual.**

Client's Name _____

Clients Date of Birth _____

☐ **Check this box: This person has undergone TB screening and has no symptoms of active TB and is cleared for entry into treatment center.**

Health Practitioner Signature: _____

Date _____

Print name: _____

Clinic Name: _____

Appendix A

To be completed by a referral worker in collaboration with the applicant. Please attach additional page(s) if needed.

Note: Only to be completed by applicants to: Tsow Tun Le Lum Program, Round Lake Treatment Centre Program, Kackaamin Family Development Centre, North Wind Wellness Centre, Gya'Wa'Tlaab Healing Centre and Wilp Si' Satxw.

Counsellor's Perspective

What is important that you need us to know about this applicant?

What is your perception of the applicant's readiness for treatment?

Has the applicant ever been violent with their partner or children? ◯ Yes ◯ No

Is the applicant willing to share about their past in a group setting? ◯ Yes ◯ No

In case of early discharge:

If travel arrangements are not pre-scheduled, can the Centre be reimbursed for Applicant's travel expenses*?

☐ Hotel ☐ Food ☐ Transportation (*Not applicable for North Wind Wellness Centre)

Who will make the reimbursement?

Presenting Problems

Please have the applicant write the answers to the following question or offer them the necessary support to respond.

Why do you want to come to treatment? Why now?

What do you believe is the treatment centre's role in your overall treatment plan?

What are Your:

Strengths (assets, resources, caring, determined, resilient, creative):

Needs (liabilities, weaknesses):

Abilities (skills, aptitudes, capabilities, talents, competencies, land-based skills):

Preferences (those things the applicant thinks or feels will enhance their treatment experience):

Presenting Problems and Challenges:

Have you experienced:

☐ Trauma (PTSD) ☐ Anxiety/Panic Disorder ☐ Anger/Acting Out ☐ Grief & Loss ☐ Sexual Harm/Abuse
☐ Foster Home Care ☐ Family Violence (Assaults/Battery/Trauma)
☐ Family Trauma (child apprehension, custody problems, lateral violence, marriage problems/breakdown, etc.)

Medical and Mental Health Reporting

If a mental health diagnosis/challenge was identified in Section 8.1, please separately provide more information including whether applicant still in treatment with doctor/psychologist, Name of doctor who provided diagnosis, and if so, a written summary of the applicant's therapy plan, how long the applicant has been mentally stable, current cognitive status and whether the applicant is able to participate in group therapy for up to eight hours and is willing to share about their past in a group setting? (please attach further information).