# Hope Mission Recovery Program

*Hope Mission is a not-for-profit social care agency founded in 1929 Edmonton, Alberta, Canada which exists to serve, strengthen and uplift men, women, youth and children through the life-changing gospel of Jesus Christ.*

**Women's Facility**
101-10336 114 Street T5K 1S3, Edmonton AB
Wellspringintake@hopemission.com
780-422-2018 ext 252 or 780-453-3412

**Men's Facility**
10635 107 Street T5H 2Y8, Edmonton AB
Breakoutintake@hopemission.com
780-422-2018 ext 312

Hope Mission Recovery Programs are long term, 12 to 14 months abstinence faith-based program. We emphasize a holistic need for recovery. Our approach includes Biblically based case management/classes, motivational interviewing, trauma informed care, cognitive behavioral techniques, peer mentors and group discussions. Below are services that will be provided for clients are in our care:

- Living accommodations/basic furnishings and 3 meals weekdays and 2 meals weekends
- Coordination with EI or Income support for program fees
- Budget assistance
- Recovery, life skills and Bible classes Monday- Friday
- Weekly Case Management meetings
- Common areas, telephone available 8 am – 10pm and television available after class
- Individual Recovery Goals
- Medication distribution
- Regular drug and alcohol testing
- Work service/volunteer planning
- Daily cleaning duties
- Opportunity for aftercare housing
- Local church partnerships
- Community events: Trips to Brightwood Ranch (when available) and social outings.
- Adherence to the Client Handbook, subject to change at any time

**CRITERIA FOR ADMISSION**
Below are the terms and conditions to remain in program. If at any time you no longer agree with these conditions, your recovery program and accommodation may be terminated. If you agree, your initials are required next to each statement.

- Participants must be stable on medications and willing to comply with medication rules
- Participants must be physically, mentally and psychologically able to participate in gym, classes and group meetings.
- Participants must be able to wake by 8AM
- Participants must be abstaining from drugs, alcohol, pornography, gambling, sexual relations and romantic relationships (including staff or any members of Hope Missions Recovery Community) ☐

- Participants must be able to complete weekly requirements including up to 20 hours a week of work service
- Participants must agree to random room checks and purchase receipts check
- Participants must participate in random drug and alcohol test
- Participants must agree to a curfew or agreed upon curfew and provide a weekly calendar stating where to go for approval by case manager
- Participants must be willing to accept personal responsibility for their own recovery and actions
- Participants must not be suicidal and not harm to themselves or others
- On medication if receiving hallucinations or paranoia
- Participants must be clean for 5 days. Detox can be accessed at ARC/Spady or Hope Mission Shelter
- Participants cannot be on any Benzodiazepines or the sleeping aids Zoplicone (Imovane) and Zoldidem (Ambien)
- Participants understand that it is a long – term recovery program and are willing to commit to 12-14 months of the program.
- Participants understand that failing drug or breathalyzer test during admission will result in no acceptance into the program and getting all the risks associated with the failed test.

**ADMISSION PROCESS**

1) Complete application package (both application forms and medical assessment)
2) Fax or email application package
3) Phone Admission Coordinator to set up an interview
4) Interview
5) Decision will be made for a participant's admission

Please email the application package (applications and medical assessment) to the correct facility.

*Hope Mission Recovery Programs have the right to deny an applicant if there is information that is withheld or false or if they do not fit criteria.*

# Hope Mission Recovery Program Application

## Application Information

| | | | |
|---|---|---|---|
| First name | Middle Name | | Last Name |
| Substitute Decision Maker First Name: | Middle | | Last name |
| Client date of Birth | Age | AHC | SIN |
| Nationality (circle one)<br>**Caucasian**<br>**African**<br>**Asian**<br>**Latin**<br>**Metis**<br>**First Nations** | **If YES to Status First Nations** | | Grade Level Completed |
| | Brand Number | | College/University Completed |
| | Treaty Number | | Read and write in English? □ yes □ no |
| | Do you ordinarily live on Reserve? If yes, name of Reserve? | | List any supports from community agencies |
| | How long have you lived off Reserve? | | Have you been incarcerated? □ yes □ no |
| Do you have a cell phone? □ yes □ no | Cell phone number: | | |
| Probation/Parole<br>□ yes(*please provide court papers)<br>□ no | Explain<br><br>Probation Officer Name/Contact # | | Where have you been staying prior to coming to the Recovery Program?<br>□ Hope Mission shelter<br>□ Other shelter<br>□ Couch surfing, family, hotel..etc<br>□ Encampment or sleeping rough<br>□ Correctional facility<br>□ Own accommodation |
| Outstanding Legal Issues<br>(Civil, Criminal, Family)<br>□ yes □ no | Explain | | |
| How many days have you been homeless?<br>□ 1-30 days □ 1-6 months □ 7-12 months □ More than 1 year<br>□ More than 2 years □ More than 3 years □ More than 5 years | | | |

## Emergency Contacts/ Supports – Automatic Consent to Contact

| | | |
|---|---|---|
| Full Name | Phone<br>Relationship | Address |
| Full Name | Phone<br>Relationship | Address |

## Income

Check all that apply
□ Alberta Works □ SFI □ EI □ AISH □ CPP □ WCB □ GST □ Tax Refund □ Past Employment □ Other(explain):

| | | | |
|---|---|---|---|
| Date of last monies received | Amount/month | Social Worker | Phone |

## Addiction History

Check all that apply
□ Alcohol □ Marijuana □ Cocaine/Crack □ Opiate/Narcotics □ Speed/Meth □ Fentanyl □ Amphetamines □ Heroin/morphine/codeine □ PCP □ Benzodiazepines □ Barbiturates □ Xylazine □ Methadone □ Propoxyphene □ Oxycodone/Hydrocodone □ Ecstasy □ Tranquilizers □ Sleeping pills □ Tobacco □ Coffee □ Porn/Sex □ Gambling □ TV □ Food □ Codependency □ Shopping □ Shoplifting

| | | |
|---|---|---|
| What is your primary addiction? | Length of Use | What is your secondary addiction? |
| Describe your recovery history(past treatment, longest recovery times, etc.) | | |
| Date of last use | Substance used | What is your recovery plan? |

## Housing History

Have you experienced homelessness for one year or more prior to entering Wellspring? □ yes □ no
If no, have you experienced 4 or more periodic episode of being homeless during the last 3 years? □ yes □ no
Have you experienced domestic abuse in the last year? □ yes □ no
If yes, are you currently in a domestic abuse situation? □ yes □ no

Are you currently involved in a relationship with someone? □ yes □ no
Do you currently know of anyone in Breakout or Wellspring? □ yes □ no
If yes, what is the name of individual: _____

## Medical History

Check all that currently applies
□ allergies □ arthritis □ asthma □ diabetes □ epilepsy □ ulcer □ stomach problems □ heart condition □ major injuries □ major surgeries □ alcohol seizures □ memory loss □ HIV □ TB □ Hep C □ other(please explain)

| Family Doctor | Phone | Address |
|---|---|---|

Are you currently under a doctor's care? If so, for what conditions?

Do you have any upcoming surgeries or procedures that would require you to take time off of program?

## Psychological History

Check all that apply
□ depression □ anxiety/paranoia □ hallucinations □ mood swings □ panic attacks □ suicidal thoughts □ suicide attempts □ anger/violence (without drugs/alcohol) □ anger/violence with intoxicants □ schizophrenia □ psychiatric assessment in the past □ psychiatric hospitalization at any time □ psychiatric diagnosis □ Bi-polar □ OCD □ multiple personalities □ FASD □ ADHD □ memory loss □ PTSD □ BPD □ other

Psychiatrist/Therapist (if no, do you need to see a mental health worker?) Explain

| Appointments | Phone/Contact |
|---|---|

**Client Consent to the Disclosure of Personal Information to Receive Outreach Support Services [1]**

Name[2]: _____
(Print name of Individual)

Required Information[3]: _____
(Date of Birth) (Client ETO Number)

I hereby authorize[4] Hope Mission

to use and disclose my individually identifying personal information① from my client file to and between the service providers as specified below[5]

□ Hope Mission Staff Members

□ Medicine Place Pharmacy

□ ODP

□ Inner city clinic

□ Probation/Parole Officer

□ Income Support

□

□

I understand the reasons for the sharing and use of the information as described below, that my consent is voluntary, and that failure to provide consent will not result in any adverse decision about my rights, benefits or services, other than limiting the ability of the organizations to work together on my behalf.[6]

I also understand why I have been asked to disclose my individually identifying health information, and have been informed of the risks or benefits of consenting, or refusing to consent, to such disclosure. I further understand that I may revoke this consent at any time.[7]

Dated and effective as of _____ of _____, _____,[8]
(day) (month) (year)

_____ _____
Signature of Client[9] Print Client's Full Name

_____ _____
Signature of Witness[10] Print Witness's Full Name

Statement of Use[11]

Personal information that is collected will be used only for the purpose of providing counseling and intervention services. Services will be delivered primarily by the service providers. Where services need to be delivered by extended service providers, information will only be disclosed to them with consent. Information will not be used for any other purpose, unless required by law, and will only be disclosed to external parties with the consent of the individual to whom it pertains.

Authority[12]

Individually, the members derive their authority from the specific legislation that they operate under, or by virtue of being a program or activity of the governing organization in order to collect, use as well as to disclose client information to other integrated service providers on a need to know basis②

This consent will expire one (1) year after the client has ceased receiving services under this program.[13]

How to use this form:

①Personal Information is as defined under the Freedom of Information and Protection of Privacy Act and includes information such as address, telephone number, date of birth, gender, criminal history, and medical history.

②For details on individual authorities, please request it from the organization's representative, or from the case-manager.

[1] This form is to be used as a method of obtaining consent to use and disclose personal client information in and between service providers. When information is not collected directly from a client, and is instead shared between organizations, this is considered "indirect collection of information". Indirect collection can only take place in limited circumstances as outlined by the Freedom of Information and Protection of Privacy Act(the "FOIP"). In these cases, where information is being collected on a regular basis, the best method is to have client consent to release and share the information on a regular basis.

This form should be printed on official organization letterhead.

[2] Add full name of client.

[3] Add date of birth and client number found in the ETO(Efforts to Outcomes) program. These are needed to ensure that the client file matches the consent form(identification verification).

[4] Name of organization doing the referral(s).

[5] List all the Outreach Support Services providers that the client is being referred to and will be working with. Form will require updated signatures if new service providers are added to the client's program(that were not originally consented to).

[6] Service will not be denied to the client if they refuse to consent. The case manager will be required to explain to the client that their information will not shared, but that the ability to provide efficient services will be hindered, and that the client will be required to have their information collected directly at each point of service.

[7] Case manager will be required to explain that the client's personal health information may be disclosed as part of this consent, butr that it will be protected at all times.

[8] Date the consent on the day the client actually signs the form.

[9] Client signature

[10] Witness signature

[11] Red (and explain) to the client the Statement of Use. This is to inform that the information is only going to be used for their participation in the program, and that any unauthorized use is against the law.

[12] Different service providers fall under various pieces of privacy legislation. All service providers are expected to know the requirements of access and privacy they must follow.

[13] The consent form must expire one (1) year after the client leaves the program. Consent must never be indefinite.

Alberta Health Services

# Residential Adult Addiction Treatment Program Application

**This medical assessment is required as part of the application and must be completed in full by a medical doctor or nurse practitioner.** The cost of fully completing this medical is covered by Alberta Health Care.

| Patient Name *(last, first, initial)* | Date of Birth *(yyyy-Mon-dd)* | Personal Health Care Number |
|---|---|---|
| | | |

Allergies *(e.g.drug, food, medical tape, other)*

**Review of Systems** *(please send relevant reports, e.g. CBC, hepatic profile, electrolytes, urinalysis, fasting blood glucose)*

EENT

| | |
|---|---|
| Respiratory *(e.g. asthma, COPD)* | Cardiovascular *(e.g. CVA, MI, HTN, arrythmia, pacemaker)* |
| Gastrointestinal *(e.g. GERD, history GI bleed, hepatitis, pancreatitis)* | Genitourinary *(e.g. incontinence, BPH, STD)* |
| Musculoskeletal *(e.g. chronic pain, RA,OA, gout)* | Integumentary *(e.g. psoraiasis, eczema)* |
| **Neurological**<br>Does the patient have a history of seizures? ☐ No ☐ Yes | Hematological/Immune *(e.g. HIV+, HCV+)* |
| Evidence of withdrawal or intoxication? *(e.g. ETHO, OPIOID)* | Other *(specify)* |

**Physical Examination**

| Height | Weight | Temperature | Pupils | Heart rate | Blood pressure | Respiration rate |
|---|---|---|---|---|---|---|
| | | | | | | |

| Skin | Diaphoresis | Tremor |
|---|---|---|
| | | |

| | | |
|---|---|---|
| Is the patient diabetic? ☐ No ☐ Yes, complete this information ▶ *(need recent HbAlc result)* | Year diagnosed | Is the patient stable? ☐ No ☐ Yes |
| Does the patient have MRSA and wound? ☐ No ☐ Yes, *(specify latest swab results)* _____ | Is there cognitive impairment? ☐ No ☐ Yes | |

Needs assistance ambulating or providing self care? ☐ No ☐ Yes

**Pregnancy**

| Is the patient pregnant? | LMP | | Para | Gravida | |
|---|---|---|---|---|---|
| ☐ No, complete top boxes only ▶<br>☐ Yes, complete **all** boxes ▶ | EDC | Urine hCG | Prenatal blood work | Prenatal ultrasound | Blood type |
| | | | | | |

Does the patient have current pregnancy complications or had a history of pregnancy complications?
☐ No
☐ Yes, specify _____

| Physician managing the pregnancy and delivery | Phone | Fax |
|---|---|---|
| | | |

Address of planned location of delivery

Alberta Health Services

# Residential Adult Addiction Treatment Program Application

| Patient Name *(last, first, initial)* | Date of Birth *(yyyy-Mon-dd)* | PHN |
|---|---|---|
| | | |

## TB Screening - Symptoms and History

| **Check the appropriate boxes** | **No** | **Yes** |
|---|---|---|
| Presence of cough lasting more than 2 weeks | | |
| Weight loss, if yes specify ____ lbs. in _____ length of time | | |
| Night Sweats | | |
| Fever | | |
| Fatigue | | |
| Haemoptysis *(blood in sputum)* | | |
| Previous active TB and treatment | | |
| Previous significant Mantoux or chest x-ray results | | |
| Extensive travel *(or birth)* in a country with high incidence of TB | | |
| Other risk factors *(i.e. aboriginal, elderly, homeless, health care worker)* | | |
| Poor general health status and risk factors for progress of disease | | |
| **Further TB screening/assessment required** -if **yes** please send results to appropriate centre | | |

## Medical Approval

In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?

☐ No ☐ Yes

| Physician or Nurse Practitioner's Name *(print)* | Signature | Date *(yyyy-Mon-dd)* |
|---|---|---|
| | | |

## Psychiatric Review/History *(send psychiatric evaluations and/or discharge summaries if available)*

**Addictions**-note date of last use, pattern of abuse and severity of addiction *(e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)*

| Primary | Secondary | Tertiary |
|---|---|---|
| | | |

**Is there evidence of the following?** *(please include your judgement related to current severity of mental health concerns)*

| ✓ | **No** | **Yes** | **Comments** |
|---|---|---|---|
| Mental, developmental and/or learning disorders *(e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)* | | | |
| Underlying pervasive or personality conditions *(e.g. personality disorders, mental retardation)* | | | |
| Acute medical conditions and physical disorders aggravating mental health *(e.g. brain injury, cognitive impairment, chronic pain, insomnia)* | | | |
| Contributing psychosocial and environmental factors. | | | |
| Global Assessment of Functioning _____ | | | |
| Is there a history of self-harm, suicidal thoughts or suicide attempts? ***(If yes, pertinent psychiatric reports/assessments are required)*** | | | |

## Psychological Approval

In your opinion is this patient psychologically stable and appropriate for admission to Residential Addiction Treatment? ☐ No ☐ Yes

| Physician or Nurse Practitioner's Name *(print)* | Signature | Date *(yyyy-Mon-dd)* |
|---|---|---|
| | | |

Alberta Health Services

# Residential Adult Addiction Treatment Program Application

| Patient Name *(last, first, initial)* | Date of Birth *(yyyy-Mon-dd)* | PHN |
|---|---|---|
| | | |

**Medications** *(if more room is needed, attach list. Send relevent laboratory results e.g. current INR, Lithium or Phenytoin level(s))*

| Medication | Dose | Route | Frequency | Reason given | Start date | End date | Prescribed by | Phone number |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**Please remind patient** that in order to be admitted to Residential Adult Addictions Treatment Program, they need to:

- Be well enough to participate in the program and remain **alcohol and drug free for at least five days prior** to admission.
- Ensure any new medications not listed above have been pre-approved by Treatment Program nurse.
- Bring enough of their medications *(in the original packaging from the doctor or pharmacist)* for their time in treatment.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Treatment Program.

| Physician/Nurse Practitioner's Name *(print)* | Signature | Date *(yyyy-Mon-dd)* |
|---|---|---|
| | | |

| Mailing address | | | |
|---|---|---|---|
| City | Postal Code | Phone | Fax |
| | | | |
| Primary Physician Name *(if different than above)* | | Phone | Fax |
| | | | |
| Other *(e.g. psychiatrist or other specialist relevant to this admission)* | | Phone | Fax |
| | | | |
| Primary Care Network affiliation? ☐ No ☐ Yes, complete this information ▼ | | | |
| Name | | Address | |
| | | | |

Physician Stamp

**Hope Mission**

**Breakout 780-422-2018(ext.216) Fax: 780-426-7507**
**Wellspring 780-453-3412 Fax: 780-426-0094**

**Re:**
**DOB:**
**Clinic Adress:**
**Tel. No:**
**Fax. No:**

To. Hope Mission Recovery Program

This letter is to confirm that _____ meets all Hope Mission Recovery Program's criteria.

*(NAME OF PATIENT)*

| _____ | _____ | _____ |
|---|---|---|
| *(NAME OF PHYSICIAN)* | *(SIGNATURE OF PHYSICIAN)* | *(DATE)* |