Gwekwaadziwin Miikan Mental Health & Addiction Program
2027 Hwy 540, Little Current ON, P0P 1K0 Phone: (705) 370-5307 Fax: (705) 370-5308

Intake Application for Seven Grandfather's Program

Gwekwaadziwin Miikan offers a 3-month residential mental health and addictions land-based program that is conducted outdoors. This co-ed, person centered program is open to all Ontario residents age 19-30 and weaves traditional culture with therapeutic best practises, education, life skills and experiential learning. We also offer a residential live-in-aftercare program available to persons that have recently completed treatment and a community after care program to assist persons with community reintegration. More information about our programs can be found on our website at www.gwek.ca.

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The application helps us understand your needs and to determine if we can assist with your healing journey. Please take time to complete the application to the best of your ability the more information you provide the better. Some of the questions may be tough to answer and it is helpful to have supports while completing this form. You can fill it in yourself, have someone you know and trust help you or call us at the number below and we can arrange a phone or Zoom call to complete it together.

The information in this application is confidential unless you provide written consent for us to share it or unless you pose a risk to yourself or someone else. We do extract some of the non identifying information for outcome measurement to understand how our program can best help people on their healing journey and how we can improve. For example, we look at the 'average' mental health of all our participants before and after the program to understand how we change lives. No individual names or identifying information is included when we pull this information from our applications and the data is grouped together.

Within 5-10 days after we get your application, our Admissions Coordinator will contact you to review your information, help you with any sections you are missing, and chat with you about the program. If you do not hear from us in the specified time frame or if your contact information changes, please call us. The application is the first step to applying but does not guarantee admission to the program, our Admissions Coordinator will discuss the next steps with you by phone.

We encourage you to look up information on our web page www.gwek.ca and watch for social media updates on our Facebook Page. When you have completed this application, you can get it to us by:
EMAIL: info@gwek.ca
Or to fill out by phone CALL US: 1-705-370-5307 (follow the prompts for Admissions Coordinator)
FAX: 1-(705) 370-5308 – Attn. Admissions

Application Steps and Stages

- To apply you must be between the ages of 19-30 years old & be eligible for a Valid Ontario Health Card.

Complete Application

- Fax, email or complete a phone application (phone 705-370-5307 ext 314, info@gwek.ca,Fax 705-370-5308 attn admissions)
- Admissions Coordinator will touch base in 5 - 10 days
- If you have a GAIN Q3 Assessment that has been completed, please attach it with your application & don't forget your consents

Answer other questions we may have

- The Admissions Coordinator will review your application within 5 - 10 day's of receiving it and determine if there is other information that we will need to move forward.
- We will obtain any additional consents that are needed
- Eg of other information may be clarifying some answers, obtaining legal or medical information, speaking with contacts

Medical

- The Admission Coordinator will provide you with a two part medical form once the above steps are completed and reviewed
- The 1st portion is to be completed by you and the 2nd portion is to be completed by a Nurse Practitioner or your Family Physician
- You should bring your portion to your appointment, the form is not lengthy and should not cost money
- The form for the Doctor or NP will have questions specific to you, we can not accept a generic medical form

GAIN Q3

- The Admission Coordinator will complete a GAIN Q3 Assessment or arrange for you to obtain one unless you have one that has been completed in the past 6 months.
- The GAIN Q3 is a standardized form that is used by Treatment Centres that helps to determine if persons are ready for Residential Treatment and to assist our program to identify if we can adequately create a successful plan based on your needs, if you are to attend.

Application Review

- Your full application will be reviewed by our Clinical Team approximatly 6 weeks prior to the start of a new cycle along with the other applications we receive.
- You will be contacted by our Admissions Coordinator to ask any outstanding questions and for weekly check ins.

Acceptance Waiting List or Referral

- You will be contacted via email or phone to advise if you have been accepted to the upcoming program, placed on the waiting list or if we do not feel we can meet your needs we will do our best to help find alternative resources that you may apply to.
- If you are accepted, details will be given to you at that time regarding exactly what you will need to do before attending

APPLICANT CONTACT INFORMATION

First Name:	Last Name:	Middle Name:	Name people usually call you
Is this your legal name? O Yes O No	If no, your legal name:	Do you have a spirit name? O Yes O No O Don't Know If yes, what is it?	
Date of Birth:	You identify your gender as:		

Marital Status: O Single O Married O Common-law O Divorced/Separated O Widowed O In a Relationship

What is your current address?	PO Box:	
City:	Province:	Postal Code:
Home Phone Number: ( ) Can we leave a message here? O Yes O No	Cell Phone Number: ( ) Can we text here? O Yes O No	

Email: Can we email you here? O Yes O No

What language(s) do you speak?
What language(s) do you understand?
What language(s) do you prefer to use?

Is the applicant completing this form? O Yes O No If no, who is helping?

Does the applicant give us permission to contact the person completing or helping with this form? O Yes O No

(If yes please complete a written consent form attached at the end of this application and send in with your application)

Phone number / email of person completing this form _____

HEALTH CARD & STATUS INFORMATION

Do you have a Provincial Health Card (e.g., OHIP card)? O Yes O No O Don't Know

Health Card Number:	Version Code (2 letters):	Expiration Date:
9-digit code at the back of Health Card:	Province of Health Card	

Are you of Indigenous heritage? O Yes O No O Don't Know
If yes, do you identify as: O First Nation O Metis O Inuit O Other _____
What is your clan, if you know it?

Do you have a status card? O Yes O No O I lost mine O Don't Know O Not Applicable (I'm not Indigenous)

10 Digit Status Number:	Band:

EMERGENCY CONTACT & PERSONAL SUPPORTS

Please complete a consent form attached at the end of this application allowing us to speak to your Emergency Contact

Name of emergency contact: Relationship to you: Phone Number: Email:	Name of emergency contact: Relationship to you: Phone Number: Email

How many positive supports do you have in your life (including professionals)?
O None O 1-3 people O 4-6 people O 7 or more people

SUPPORTIVE FRIENDS & FAMILY MEMBERS THAT YOU WOULD LIKE TO STAY IN CONTACT WITH DURING PROGRAM	
Please check yes or no if you are consenting for us to speak to your supports & complete a written consent at the end of this application	
Name : **Relationship to you:** **Phone Number :** **Email**	Consent to contact O Yes O No
Name: **Relationship to you:** **Phone Number :** **Email**	O Yes O No
Name **Relationship to you:** **Phone Number:** **Email**	O Yes O No
AGENCY & PROFESSIONAL CONTACTS (Include consents if you check yes)	
Doctor / Nurse Practitioner and Clinic Name: **Clinic Name / Address:** **Phone Number:**	O Yes O No
Dentist: **Clinic Name / Address:** **Phone Number:**	O Yes O No
Counselor **Clinic Name / Address:** **Email:** **Phone Number:**	O Yes O No
Psychiatrist / Psychologist: **Clinic Name / Address:** **Email:** **Phone Number:**	O Yes O No
Child Welfare Worker & Agency : **Email (if you have):** **Phone Number:**	O Yes O No
Lawyer Name: **Address:** **Email:** **Phone Number:**	O Yes O No
Probation/Parole Officer : **Email:** **Phone Number**	O Yes O No
Other Agency Name: **Contact person's name:** **Phone Number :** **Email**	O Yes O No
Other Agency Name: **Contact person's name:** **Phone Number :** **Email**	O Yes O No

EMOTIONAL HEALTH

Why are you interested in treatment at Gwekwaadziwin?

People who are looking for treatment often struggle with mental health and learning differences. To plan for your success, let us know your history of mental health & learning differences and check the box that best describes the impact of each issue.

	Do you experience?	Formally Diagnosed?	Age this started?	Major impact	Fairly serious	Some impact	No impact
Anxiety	O Yes O No	O Yes O No					
Depression	O Yes O No	O Yes O No					
Bipolar Disorder	O Yes O No	O Yes O No					
Eating Disorder	O Yes O No	O Yes O No					
Obsessive Compulsive Disorder	O Yes O No	O Yes O No					
Panic Disorder	O Yes O No	O Yes O No					
Post-Traumatic Stress Disorder	O Yes O No	O Yes O No					
Schizophrenia	O Yes O No	O Yes O No					
Social Phobia	O Yes O No	O Yes O No					
Attention Deficit Disorder or ADHD	O Yes O No	O Yes O No					
Fetal Alcohol Effects / Spectrum	O Yes O No	O Yes O No					
Psychosis	O Yes O No	O Yes O No					
Oppositional Defiant Disorder (ODD)	O Yes O No	O Yes O No					
Conduct Disorder (CD)	O Yes O No	O Yes O No					
Other Mental Health Issue _____	O Yes O No	O Yes O No					
Learning Disability (not ADD/ADHD)	O Yes O No	O Yes O No					
Intellectual Disability	O Yes O No	O Yes O No					
Other that we should be aware of							

If you answered yes to any of the above, please tell us any coping strategies you use to help with these issues.

Thinking about your life over the last 45 days, circle the most appropriate response to the right:	Very Poor	Poor	OK	Good	Excellent
Physical health	VP	P	OK	G	E
Emotional Wellness	VP	P	OK	G	E
Mental Wellness	VP	P	OK	G	E
Spiritual Wellness	VP	P	OK	G	E

Describe 4 things in your life that are going well for you at this time:

- ✓
- ✓
- ✓
- ✓

Describe 4 things that you would like to improve in your life at this time:

- ✓
- ✓
- ✓
- ✓

Do you get angry often or easily? **O Yes O No**

In the last 3 months, how many times did you regret being angry?

O None **O** Once a month **O** A few times a month O Weekly **O** Multiple times per week O Daily

How would your family or close friends know that you are happy and having a good day?

How would your family or close friends know that you are angry?

Previous Treatment. Please tell us about any other programs you have attended.

	Name of Program	**Type of Program**	**How long did you attend?**	**Month/year of last session**	**Did you finish?**
Most Recent					O Yes O No
Next Most Recent					O Yes O No
Third Most Recent					O Yes O No

Health

When was the last time you had a medical or regular planned visit with your Doctor to discuss your health?

O In the last 3 months O 4-12 months ago O 1-5 years ago O over 5 years ago

In the last 3 months, how many times did you visit a hospital emergency room?

O None O Once O 2-3 times O 4-15 times O 16-30 times O More than 30

Do you have any medical concerns that we should be aware of that may impact your ability to take part in the Land Base Treatment Program?

Do you require any dental work prior to attending Treatment?

Do you have any allergies (list all medical or food allergies and reactions to each)

Do you require an epi pen or allergy medication for reactions

Health Continued

Please list any prescription, non-prescription, or herbal medications you are currently taking:

Name	Dosage (mg)	Time you take it & how much	What is it for

How physically active are you? O Not at all O A little O Active more days than not O Most days

In the past 3 months, how often do you do outdoor activities?
O Not at all O A little O More days than not O Most days

What activities do you enjoy?

Personal Safety

When was the last time, if ever, you cut, burned, or hurt yourself on purpose? **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
When was the last time, if ever, you thought about ending your life? **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
When was the last time, if ever, you had a plan to end your life? **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
When was the last time, if ever, you attempted to end your life? **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
Are you concerned for your personal safety **If yes, please tell us about it:**	☐ No ☐ Yes
When was the last time, if ever you were involved in a domestic abusive relationship **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
When was the last time, if ever, you were involved with a Gang? **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month
Human Trafficking **When was the last time, if ever, you were involved with Human Trafficking?** **If you ever have, please tell us about it:**	O Never O More than a year ago O 6-12 months ago O 3-6 months ago O In the past month

ALCOHOL & DRUG USE

*Tell us about your use of drugs and alcohol over the last **3 MONTHS** (90 days)*	**Ever Used It?**	**Age You First Used It**	**In the last 90 days, on how many days did you use this substance?**
METHADONE OR SUBOXONE	☐ No ☐ Yes		
ALCOHOL	☐ No ☐ Yes		
TOBACCO (cigarettes, vape)	☐ No ☐ Yes		
MARIJUANA	☐ No ☐ Yes		
POWDER COCAINE	☐ No ☐ Yes		
OR ROCK COCAINE (crack, freebase)	☐ No ☐ Yes		
INHALANTS (glue, gasoline, whiteout)	☐ No ☐ Yes		
METH/AMPHETAMINES (Ecstacy, MDMA, Speed)	☐ No ☐ Yes		
TRANQUILIZERS not prescribed (benzos, ludes, valium, goofballs, roofies, prozac)	☐ No ☐ Yes		
BARBITUATES (barbs, downers, sleepers, reds)	☐ No ☐ Yes		
FENTANYL	☐ No ☐ Yes		
KETAMINE ("K")	☐ No ☐ Yes		
OPIATES (heroin, morphine, oxy, percs, hydro, codiene)	☐ No ☐ Yes		
HALLUCINOGENS: (Mushrooms, Datura, LSD, peyote)	☐ No ☐ Yes		
PCP (angel dust)	☐ No ☐ Yes		
OVER THE COUNTER MEDS (cough syrup, pain relievers, antihistamines)	☐ No ☐ Yes		
PRESCRIPTION DRUG(S) NOT prescribed (e.g. OxyContin, Ritalin) Which ones _____	☐ No ☐ Yes		
NICOTINE	☐ No ☐ Yes		
OTHER DRUGS Which ones _____	☐ No ☐ Yes		
Is your goal to be completely substance & alcohol-free following treatment?	☐ No ☐ Yes		
Is your goal to reduce risk and implement harm reduction? If yes which substance do you see yourself continuing to use)	☐ No ☐ Yes		
Which substance(s) do you use the most?			
Which is your substance of choice (if you had access)?			

LEGAL INFORMATION

Do you have a criminal record? O Yes O No
If yes, please tell us about it _____

Do you have any charges pending? O Yes O No
If yes, what are they? _____

Do you have upcoming court dates? O Yes O No
If yes, when. _____

When was the last time, if ever, you:

Were involved with damaging or vandalizing property?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Were involved in illegal activities, besides drug use?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Had police contact for illegal behaviour without arrest?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Instigated any sexual misconduct or aggression?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Were charged with any crimes against a child or children?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Committed or were charged with fire setting or arson?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Committed or were charged with a non-violent offence? (e.g., theft)	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Committed or were charged with a violent offence (e.g., weapons, assault)	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Were involved with a justice diversion program?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Were on probation or parole?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month
Had a restraining order placed against you?	O Never O More than a year ago O 4-12 months ago O 2-3 months ago O In the past month

HOME, WORK, & FAMILY

Do you currently have stable housing? O Yes O No

Do you consider this your home? O Yes O No

If not, where do you consider home?

If not, what is your living arrangement? O Living on street O Couch surfing O Shelter O Other _____

Do you have a safe place to live after treatment? O Yes O No O Don't know

Who do you currently live with?

Do you have children? O Yes O No If yes, how many?

Are any of your children involved in the child welfare system? O Yes O No O Don't know

If yes, provide worker name, number, email address in the '*supports*' section above

Please provide the names and ages of each of your children, and tell us who they live with:

What is your main source of income?
O Employed F/T O Employed P/T O EI O Ontario Works O ODSP O No income O Other _____

If employed, name of employer:

What is the highest level of education you have completed?
O Elementary O Some high school O High school
O Trades certificate O College Diploma O University Degree O Other _____

Are you currently enrolled in school? O Yes O No

Are you currently attending school? O Yes O No

Do you hope to return to school? O Yes O No If Yes Please tell us about this?

	1 being Extremely difficult									**10 being Not at all difficult**
How difficult is reading for you?	1	2	3	4	5	6	7	8	9	10
How difficult is writing for you?	1	2	3	4	5	6	7	8	9	10

FAMILY HISTORY & CULTURAL INFORMATION

Did any of your family members attend Residential School? O Yes O No O Not sure
Who: _____

Were you, your parents, or grandparents involved with the Child Welfare System? O Yes O No O Not sure
Who: _____

Are you aware of the impacts of colonization? O Yes O No O Not sure

In the last 3 months have you been exposed to Indigenous Language? O Yes O No

Do you feel connected to your cultural identity? O Yes O No O Not sure

Please tell us about that:

In the last 3 months, have you spoken with an Elder or Knowledge Keeper? O Yes O No O Not sure

If yes, please tell us about that

In the last 3 months, have you heard or practiced any traditional teachings? O Yes O No O Not sure

If yes, please tell us about that
In the last 3 months, have you practiced any spiritual, ceremonial or religious teachings or practices (e.g., attending ceremonies, church, smudging, fasting etc.)? O Yes O No O Not sure
If Yes was this a positive experience for you? O Yes O No
Are there any Spiritual practises that you would like us to know about that are important to you?
Do you feel you have gifts, strengths, or talents? O Yes O No O Not sure
If yes please tell us about some of them
If there is anything else you would like for us to know about you, please tell us here.

I agree to admittance into the Gwekwaadziwin Miikan Treatment Program and to the collection of personal information as required for admission, treatment, research, and outcome measures.

I understand that the program is completely voluntary, and I may choose to leave the program at anytime but that Gwekwaadziwin asks for 7 day's notice before leaving the program so that they can assist with a safe departure as a transition back to community and time to gather my personal belongings from locked storage. This time also allows me to make an informed decision for myself and to work with the Community After Care Worker to secure alternate supports. Transportation will ultimately be my responsibility, but they will assist with calls and arrangements if the 7 days notice is provided.

I understand the archival and use of personal Information Is protected by confidentiality and (PHIPA) Personal Health Information Protection Act. Personal Information will not be shared without written consent unless ordered by a court of law; or if I present as a danger to myself or others, or If a concern is considered pertaining to my treatment in an emergency.

In the event of a medical emergency, that cannot be mitigated by the Gwekwaadziwin Miikan staff we will ensure the care is received at the nearest Emergency Centre and the emergency contact will be notified as soon as possible.

The information contained in this application is true to the best of my knowledge. Please print and sign or acknowledge that you agree by typing in your name and date. If a referral source is completing the info on your behalf we will require your signature.

Applicant Signature: _____ Date:_____

Gwekwaadziwin Miikan
2027 Highway 540,
Little Current, Ontario P0P 1K0
Tel. (705)-370-5307
Fax. (705)-370-5308
Email: info@gwek.ca

Gwekwaadziwin Miikan **2027 Highway 540, Little Current, Ontario** **Tel. 705-370-5307 | Fax. 705-370-5308**	**Participant Consent Form** **For Referrals**

Consent for Emergency Contact

I, _____ (Full Name of Participant),
born on _____(Date of Birth), hereby authorize the Gwekwaadziwin Miikan Treatment Program to **RELEASE/REQUEST** the following information to/from the person/agency listed. In order for this release to be valid, please check yes or no to areas of disclosure.

Emergency Contact: _____

Contact Information: Tel. _____ Work Cell._____
Fax. _____ Email._____

Area of Disclosure:	**Yes**	**No**
1. Assist with the application process/Updates	☐	☐
2. Confirmation of Attendance/Completion	☐	☐
3. Assessment, Treatment Planning Info & Discharge Summary	☐	☐
4. Reports	☐	☐
5. Medical Information	☐	☐
6. Legal Status (i.e. court cases, parole, probation)	☐	☐
7. Other:_____	☐	☐
_____		

I understand that no other information will be released to any other person without my written consent unless these persons have a court order or subpoena, or I present as a danger to myself or others; or considered a concern with my treatment in an emergency situation. This consent is valid for the duration of the participants current admission to the program. Participants can opt out of this consent in writing anytime.

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

	**Gwekwaadziwin Miikan** **2027 Highway 540, Little Current, Ontario** **Tel. 705-370-5307 | Fax. 705-370-5308**	**Participant Consent Form** **For Referrals**

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