The Bridge Addictions Services
Assisted Living, Supported Recovery Program

QUESTIONS OR GENERAL INQUIRIES
For program inquiries please contact The Bridge Youth and Family Services at 250-763-0456 | info@thebridgeservices.ca | www.thebridgeservices.ca
SUBMITTING APPLICATION
Please indicate your preference in Supported Recovery location: ☐ Supported Recovery Kelowna ☐ Supported Recovery Penticton ☐ No preference **Please fax completed application to:** **250-493-5615 or 250-763-4910**

OUR VISION

Resilient Communities Where Everyone Thrives.

OUR MISSION

We inspire healthy communities and resilient people through innovation, leadership and collaboration. The Bridge strengthens communities, families and people by offering a constellation of services and programs that reflect our commitment to the incredible potential of all we are honoured to serve.

Participants build off of their treatment program and continue to develop the skills needed to generate a sustained recovery experience. They are responsible to engage their personal treatment transition plan and are encouraged to access community resources and to generate healthy connections that will carry them forward on their personal journey.

The Program

- is a balance of support, structure and independence
- picks up right where residential treatment stops creating a smooth continuum of support
- is offered in a safe, substance free, live-in environment
- respects the participants right to self determination
- seeks to intervene before stress becomes crisis
- supports cultural, gender and sexual diversity
- addresses mental health and substance use issues simultaneously

Admissions

Fundamentally, a candidate for Bridge SR Program needs to be post treatment, engaged and actively motivated for change. Having initiated Withdrawal and/or Treatment phases and completing with success, our program should be considered a stepping stone to independence or another level of care, and not a long-term answer.

It is also possible that a candidate could be "Second Stage" *without* being post residential treatment, if Treatment (Facility Based or full-time outpatient) is determined *not* to be required by a supporting professional. Individuals with complex and/or chronic substance misuse for whom community-based treatment approaches have not been effective will often find that time in a supportive environment can provide opportunity to practice the skills required in the stages of "early recovery". All applicants require a local (Interior Health) Mental Health and Substance Use (A&D) referral, and admissions are screened by program staff. All applications are screened by the Program Manager and an IHA MHSU liaison; applicants participate in a pre-interview when ever possible before determining approval into the program.

Programming

Programming is provided in the way of group and individual support for day-to-day social skills development in the form of recreation and life learning opportunities. Along with healthy coping strategies for stress, relapse prevention and sustainable recovery concepts are developed and practiced. Counselling services are provided by Interior Health clinicians and Wellness support comes from the Program Manager and staff. Opportunities for recreation and fitness activities are provided regularly and participation encouraged.

Program highlights:

- IHA outpatient groups - such as Recovery Essentials and Relapse Prevention
- Clinical and Community Groups on campus
- Yoga, Massage, Access to the Community Recreation Centers and Group Recreation Activities

Transition Planning

All participants will develop and implement their own transition strategy for departure from SR. Work on a Service Plan will begin early and will be a collaborative process between the participants, staff and the appropriate community-based resources. It will also involve the participant's family or other supports and, whenever possible, a family session will be held with the participant and family members to work collaboratively on the service plan and transition. Participants will leave our program with confidence in their capability to continue growing and sustaining their new healthy lifestyle.

Participants that leave the program prior to completion (either voluntarily or involuntarily) will be treated with dignity and respect. Support with an emergency transition plan and assistance with returning to the community will be provided.

Refer to the application document check list to ensure that you have the proper documents filled out by the proper person or resource.

THE BRIDGE SUPPORTED RECOVERY PROGRAM APPLICATION CHECK LIST

Application for Admission - A&D Counsellor/ Referral agent please assist in completing the application.

- ☐ Participant information (page 5 to 10)
- ☐ Early Exit plan – Filled out with referral agent (page 14)
- ☐ Participation Agreement is signed by Applicant (page 15)
- ☐ A Voluntary Consent to Release Information Form for individuals that applicant would like the Bridge Addictions Services to share information with (page 16) --signed by A&D/ MHSU counsellor
- ☐ Supported Recovery Expectation and Goals (page 17)
- ☐ Supported Recovery Cohabitation Information (page 18)

- ☐ Pre-Admission Medical Status Questionnaire **completed by an applicant** (page 10)
- ☐ Prescription form **completed by a physician whenever possible** (page 11)
- ☐ Proof of symptom and risk assessment with note of clearance for entry from assessor - **Copy of results included**

- ☐ Funding Information Form (page 12)
- ☐ Ministry of Social Development and Poverty Reduction Proof of Income Form **stamped and approved** by the Ministry (page 13 if applicable)

Upon receiving the completed package your application will be reviewed by the Program Manager and MHSU liaison to determine your eligibility to enter the program. An interview will be conducted with the applicant whenever possible, and then admission status is determined. Participants waitlisted may be required to provide updated information for their application.

REFERRAL FORM

Date of referral (day/month/year):	
Applicant's Legal Name:	**Preferred Name(s):**

Referral Criteria

- A referral may be made by any member of the applicant's care team, but preference will be given to those applicants connected to Mental Health and Addictions Services. Please complete in collaboration with your client, not by the applicant on their own.

Admission Criteria

- Applicants who have more complex and/or chronic substance use for whom community-based treatment approaches have not been effective.
- BC resident age 19 and older; and
- Independence in activities of daily living.

REFERRAL INFORMATION

Health Region: ☐ Interior Health ☐ Northern Health ☐ Island Health ☐ Fraser Health ☐ Provincial Health ☐ Vancouver Coastal Health ☐ Providence Health ☐ First Nations Health Authority ☐ Other: _____

Referral Agent Name:		
Name of Organization:		
Address:	City & Postal Code:	
Phone Number:	Fax:	
Email Address:		
Case Manager's Name: (if different from Referral Agent Name):		
Is applicant's Case Manager aware of this application? ☐ Yes ☐ No (If no, please advise them now)		
Name of Case Manager's Organization:		
Address:		
Phone Number:	Fax:	
In the past three months how many Clinical appointments have you had with your client? _____		
What type of service has your client accessed?	Individual counseling: ☐ # of sessions? _____	Group Counseling: ☐ # of sessions? _____

CLIENT INFORMATION

Self-Identified Gender (*Select all that apply*):
☐ Female ☐ Male ☐ Transgender ☐ Non-Binary ☐ Two-Spirit ☐ Questioning ☐ My Gender is _____

Pronouns:
☐ She/Her ☐ He/Him ☐ They/Them ☐ My Pronouns are: _____

Date of Birth (YYYY/MM/DD):	Age:	Address:
City:	Province:	Postal Code:
Email:	Telephone:	Is it okay to speak to members of your household? ☐ Yes ☐ No
BC Care Card #:	SIN:	

Please indicate your client's highest educational level completed:

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Widowed

Pregnant: ☐ Yes ☐ No	Pregnancy Due Date:

Does the client have minor children? ☐ Yes ☐ No

Names (write below)	Age (write below)	If under 19, what is the child's current living situation? (write below)

Is your client the custodial parent? ☐ Yes ☐ No

If no, who has custody of child(ren)?

CULTURAL INFORMATION

Ethnicity:	Primary Language:

Are there barriers any to communication? ☐ Yes ☐ No
If yes, please specify:

Any cultural specific care/ practice: ☐ Yes ☐ No
If yes, please specify:

Does the applicant identify as an Indigenous Person?
☐ Indigenous ☐ Non-Indigenous ☐ Unknown ☐ Prefer not to answer

Predominantly Lives: ☐ On reserve ☐ Off reserve ☐ On and Off reserve ☐ Prefer not to answer

First Nations Status: ☐ Has Status ☐ Non-Status ☐ Pending Status

Status #:	Band Name:

EMERGENCY DESIGNATED CONTACT PERSON (Family/Friends)

Name:	Relationship:
Telephone:	Email:

SUBSTANCE USE TREATMENT HISTORY

Has your client completed a withdrawal management program? ☐ Yes ☐ No

If yes, please list dates and where:

Prior Treatment and/or Counselling History (Please list all previous treatment and dates):

Name of Agency	City	Start & End Dates	Completed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If no previous residential treatment history, why?

Please provide a brief explanation of your client's motivation and purpose for seeking support through the Bridge Addiction Services:

Applicant: In your own words, please explain why you wish to attend Bridge Addiction Services?

HISTORY OF SUBSTANCE USE CONCERNS

Substance(s) Used (DOC)	Method of Use (Inject, smoke, snort, ingest)	Date last used (DD/MM/YYYY)	# Days of use in last 30 days	Typical amount/quantity used daily	Age at first use

HISTORY OF PROCESS CONCERNS

Process	Date last active	# of days active in last 30	Age at first experience
Pornography Addiction			
Shopping Addiction			
Sexual Addiction			
Other Addiction i.e. Gambling/Internet (Please Specify)			
Disordered Eating: • Binging			
• Purging			
• Restricting			

Abstinent at time of application? ☐ **Yes** ☐ **No** **Abstinent Date (if applicable):** _____

Participants must be capable of participating in programming upon admission; Participants arriving that require a medical withdrawal management program may not be admitted.

SAFETY CONCERNS

Suicide Ideation/Suicide attempts: ☐ Yes ☐ No

If yes, please summarize and date most recent:

Overdoses: ☐ Yes ☐ No

If yes, please summarize and date most recent:

Aggression/anger: ☐ Yes ☐ No

If yes, please summarize and date most recent:

Current domestic violence: ☐ Yes ☐ No

If yes, please summarize and date most recent:

HOUSING / ACCOMMODATION

Does your client currently have safe housing? ☐ Yes ☐ No

What type? _____

(e.g. house, apartment, family/friend, supportive housing, etc.)

Is your client currently homeless? ☐ Yes ☐ No

If yes, please provide details:

Does your client have safe housing/accommodations arranged for after The Bridge Addictions Services? ☐ Yes ☐ No

If yes, please explain:

LEGAL HISTORY/STATUS INFORMATION

Referrals submitted from Correctional Facilities **will not be accepted** with unknown release dates. Please only submit a completed referral package once release date has been set.

Does the applicant have any criminal history: ☐ Yes ☐ No

If yes, this form **must** be completed.

Has your client ever been convicted of a violent crime? ☐ Yes ☐ No

If yes, please provide details:

Does your client have any Charges Pending? ☐ Yes ☐ No

Upcoming court dates?

Are you on Parole? ☐ Yes ☐ No	Are you on Probation? ☐ Yes ☐ No	Currently Incarcerated? ☐ Yes ☐ No

Release date is:

Probation/Parole Officer Name:

Phone number:	Fax:

Please list previous/current charges and dates:

Date	Specific Charge	Sentence

What was your client most recently convicted of?

Sentence Length: _____ ☐ Conditional Sentence ☐ Probation ☐ Incarceration
Has the client ever served Federal time? ☐ Yes ☐ No If yes, have they reached warrant expiry? ☐ Yes ☐ No

I consent for The Bridge Addictions Services to release and exchange any pertinent information regarding my legal history with any legal agencies associated with me. (I.e. lawyer, probation officer etc.)

Client Name: _____
(please print)

Client Signature: _____ **Date Signed:** _____

PSYCHIATRIC HISTORY

Psychiatric Diagnosis:	☐ Depressive Disorder	☐ Anxiety Disorder
	☐ Bipolar Disorder	☐ Eating Disorder
	☐ Personality Disorder (please specify)	☐ Other: _____
	☐ Schizophrenia or other psychotic disorder	

Is your client's disorder stable? ☐ Yes ☐ No

If yes for how long? Is there any impact on daily life? If so, please explain:

MEDICAL HISTORY

Has your client been hospitalized in the last 30 days? ☐ Yes ☐ No If yes, please detail below:	
History of seizures: ☐ Yes ☐ No If yes, please explain:	
Last TB symptom and risk assessment (Date): _____	**Include symptom and risk assessment with this application and note of clearance for entry from assessor.** Must be completed within the **past six months** for admission.
Past Surgeries (Date): ☐ Yes ☐ No If yes, please detail below:	
Mobility Issues: ☐ Yes ☐ No If yes, please detail below:	
Cognitive Impairment: ☐ Yes ☐ No If yes, please detail below:	
Head Injury (due to assault, MVA, concussion or unconscious): ☐ Yes ☐ No If yes, please detail below:	
FASD: ☐ Yes ☐ No If yes, please detail below:	

PRE-ADMISSION MEDICAL STATUS QUESTIONNAIRE

To Be Completed by Applicant

First Name:		Last Name:	
Date of Birth:		Patient Phone #:	
Province:		Personal Health Number:	
Height:	Weight:	BP:	Pulse:
Drug/Food Allergies:			

Medication:
Please check all categories representing types of prescription medication that are currently being used:

☐ Anti-depressants ☐ Anti-anxiety ☐ Anti-psychotic ☐ Pain medication

☐ Other (specify): _____

Methadose/Suboxone:

Length on Methadose program: Current dose: _____ml.

Length on Suboxone program: Current dose: _____mg.

Length of time on current dose:

Prescribing Physician's name:	Phone number:

Medical History:
Current health/dental symptoms/conditions/diagnosis:

Have you suffered seizures in the past year: ☐ Yes ☐ No

If yes, were these seizures withdrawal related: ☐ Yes ☐ No

If not withdrawal related, do they have a seizure disorder: ☐ Yes ☐ No

If yes, please describe:

I am medically and physically capable of participating in an abstinence based residential program for substance misuse.

Client Name: _____ **Date:** _____

(please print)

Client Signature: _____ **Date of Brith:** _____

ALL applicants are required to provide a current negative TB Test result.

CURRENT PRESCRIPTION FORM

To Be Completed by a Physician Whenever Possible

Dear Doctor:
In order to facilitate admission to our program as quickly as possible, we request that you provide written orders for all required medications. Please write out all orders for the duration your patient will be attending. The Bridge requires participants to **bring originals of all triplicate prescriptions** with them for their admission date.

Patient Name:	Date:
Date of Birth:	Personal Health Number:
Drug/Food Allergies:	

℞

Medication:	Reason/Instructions for Use:

Any Additional Required Non-Prescription Medication:	

Physician's Name: _____ **Phone Number:** _____

(please print)

Physician's Signature: _____ **License number:** _____

All medications must comply with our medication administration policies.
Please contact our office at 250-763-0456 if you have any questions.

FUNDING INFORMATION FOR BRIDGE SUPPORTED RECOVERY

There is a per diem cost for the Supported Recovery Program of $60.00 per day.

- Applicants receiving Income Assistance may apply for coverage through the Ministry of Social Development (form attached). **The client must present this form to the Ministry for completion.** When completing the Confirmation of Income form, ensure that the address selected corresponds to the client's chosen Supported Recovery site:
  - ↳ **Supported Recovery – Penticton (Women), Johnson House:** 1001 Johnson Rd, Penticton, BC V2A 1W3
  - ↳ **Supported Recovery – Penticton (Men), Nanaimo House:** 123 Nanaimo Ave East, Penticton, BC V2A 1M3
  - ↳ **Supported Recovery – Kelowna:** 760 Hwy 33 West, Kelowna, BC V1X 7Y5

  Once finalized, please submit the completed form along with all other required application documents.
- First Nations applicants may approach their Band for funding; FNHA also supports funding requests for Supported Recovery.
- Applicants not receiving funding assistance may qualify as Self-pay applicants (cost= $35.90/day) and must submit a signed letter confirming they are prepared to remit full payment on the first of each month. Participants are responsible for the cost of all medications while in the program.

Supported Recovery program for _____ will be paid by (please check one box below):
Applicant's name

☐ Applicant/Family Paid – Please provide a dated and signed letter from the payee confirming responsibility for per diem payment, along with:

Name (if different than above): _____

Address: _____

Phone: _____

☐ Ministry of Social Development and Poverty Reduction - Please complete the required form on the next page.

☐ Employer Paid – Please attach a confirmation letter from the employer.

Employer: _____

Contact: _____

Address: _____

Phone: _____

Email address: _____

☐ Band Paid – A representative from the Band must contact the Program Manager to arrange per diem payments.

☐ Other: _____

THE BRIDGE Youth & Family Services

Interior Health

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

Service Provider Name	Fax Number
Address	

Clients receiving assistance from the Ministry of Social Development and Poverty Reduction must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Poverty Reduction.

Client Full Name		
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Poverty Reduction to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature _____ Date Signed _____

To be completed by ministry staff

Does the client have an open file? ○ Yes ○ No

Is the client receiving any other income? ○ Yes ○ No

Source of income _____

Amount of income _____

Is the client pending any other income? ○ Yes ○ No

Source of pending income _____

Notes

Ministry Staff Signature _____ Date Signed _____

*Be advised information is accurate as declared to the Ministry as of the date signed.

EARLY EXIT TRANSITION PLAN

The following plan will be put in place if I leave early from The Bridge Addictions Services. I understand that as I continue treatment staff will assist me to develop a more complete transition plan to ensure my continued support and recovery when returning home.

It is understood that if I leave the program early or if I do not arrive for my scheduled intake, my referral liaison and my emergency contact will be notified immediately.

Destination upon early exit:	
Address:	City:
☐ Shelter ☐ Other MH&A Facility ☐ Residence ☐ Supportive Housing ☐ Independent ☐ Other (please specify): _____	

COMMUNITY CONTACT FOR EARLY EXIT SUPPORT

Name:	Telephone:	Email:

CRISIS PLANNING PROCEDURES

The following plan will be implemented should my mental health status become critical, I will:

SIGNATURE

By signing below, I consent to my referral liaison and emergency contact being contacted should I leave the program early.

Client Signature:	**Date:**

PARTICIPATION AGREEMENT – PLEASE REVIEW / COPY AND GIVE TO APPLICANT

I have agreed to apply to The Bridge Addictions Services and have reviewed the program services available. I understand that The Bridge Addictions Services is an abstinence-based program and I agree with the following:

- ❑ I will participate in the following activities upon arrival to The Bridge Addictions Services and commit to the Program(s)
- ❑ Participate in a medication review upon intake.
- ❑ Will treat others with respect, dignity and without discrimination.
- ❑ Participate in an assessment and development of a treatment plan and follow this treatment plan.
- ❑ Participate in group and individual counselling programs.
- ❑ Will follow the 1-week stabilization period where limited contact/ off property restrictions are encouraged unless prearranged with the Residence Supervisor or if there is an urgent need.
- ❑ Work with staff to coordinate a transition plan for completion of the program.
- ❑ Follow program guidelines including no violence and no recruitment of others into gangs or prostitution.
- ❑ Will abstain from all drugs, alcohol, and cannabis except medication prescribed by the program physician during my treatment (we are not able to accommodate medical marijuana prescriptions)
- ❑ Will not use scents during my stay.
- ❑ Will keep all information about other program participants confidential.
- ❑ Will provide urine drug screens and breathalysers when requested by the staff.
- ❑ Will provide access to all prescription and non-prescription medications to the staff.
- ❑ Will share an apartment during my stay and will keep it clean and clutter free.
- ❑ Will not have individuals in my bedroom room except for staff.
- ❑ Staff may conduct random room searches in my room throughout my stay at the centre.
- ❑ Will take all my belonging upon discharge. Belongings left after discharge from the centre will be donated to charity
- ❑ Will smoke/vape in designated smoking area(s) only.
- ❑ Refunds are not available within the Supported Recovery Program.

SIGNATURE

Client Signature:	**Date:**

Participants may bring a vehicle but should be aware that there is a limited amount of secure parking available.
A telephone is available for local calls and where messages can be left for you from outside callers.

VOLUNTARY CONSENT FOR RELEASE OF INFORMATION

The Bridge Addictions Services maintains strict personal confidence rules. Without written consent to release information, we will neither confirm nor deny that you are in our programs. We do, however, need to speak to certain person(s) or agencies for the purpose of obtaining or providing information that will be helpful to your treatment plan please consider and add additional people not previously mentioned such as lawyer, social worker, probation officer, counselor and/or extended family members.

Name	Relationship to applicant	Phone number	Client Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supportive Recovery Applicant's please note your Interior Health Clinician is already included:

Name: _____

Office: _____ **Phone:** _____

I, _____, consent for The Bridge Addictions Services to receive, release and
(Please print applicant's name)
exchange information with any and all person/agencies listed on this referral.

_____ _____

Applicant Signature **Date**

_____

Witness

I, _____, have reviewed the provided information and am supportive of this
(Please print referral agent's name)
application and believe this applicant to be an appropriate fit for The Bridge Addictions Services.

_____ _____

Referral Agent Signature **Date**

SUPPORTED RECOVERY EXPECTATIONS AND GOALS

Why do you feel the need to access the Supported Recovery Program?
What are your goals, that you wish you accomplish during your participation in the Program?
What kinds of support do you think you'll need to be successful in the Supported Recovery Program?
What do you think you will find most challenging about participating in the program?
Are you comfortable doing daily tasks of living such as but not limited to: Cooking meals, washing dishes, doing laundry, grocery shopping, bathing, and housekeeping?

SUPPORTED RECOVERY COHABITATING INFORMATION

How would you describe your standards of cleanliness? (Circle one)

- ☐ 1) Incredibly clean and organized
- ☐ 2) Mostly clean and organized
- ☐ 3) Kind of clean and organized
- ☐ 4) Kind of messy and unorganized
- ☐ 5) Very messy and unorganized

How would you describe your sleeping patterns? (Circle one)

- ☐ 1) Stay up late and wake up late
- ☐ 2) Stay up late and wake up early
- ☐ 3) Go to bed early wake up early
- ☐ 4) Go to bed early wake up late
- ☐ 5) Erratic sleeping patterns

What level of noise are you most comfortable with in your space? (Circle one)

- ☐ 1) Loud music and or TV all Day and Night
- ☐ 2) Loud music and or TV Through most of the day but quiet at night
- ☐ 3) Medium volume music and or TV on all day and night
- ☐ 4) Medium volume Music and or TV during the day but quiet at night
- ☐ 5) Quiet music and or TV all day and night
- ☐ 6) Quiet music and or TV during the day but quiet at night
- ☐ 7) Prefer complete quiet in your space most of the time

How much social interaction do you like? (Circle one)

- ☐ 1) I like people around me all the time, I gain energy from interacting with people
- ☐ 2) I enjoy having people around me most of the time, and gain energy from the time I spend with them
- ☐ 3) I like a mix of social time and alone time, and need both to recharge my batteries
- ☐ 4) I value a great deal of alone time in my day, and require alone time to feel recharged
- ☐ 5) I feel best being completely alone during my day, and require alone time to feel recharged