

# Bridgeway Treatment Program Application

## Part 1: Pre-Screening Application

### QUESTIONS OR GENERAL INQUIRIES

For inquiries about the Bridgeway Treatment Program please contact:  
 250-763-0456 | [bridgeway@thebridgeservices.ca](mailto:bridgeway@thebridgeservices.ca) | [www.thebridgeservices.ca](http://www.thebridgeservices.ca)  
 265 Gray Road, Kelowna, BC V1X 1W8 | 1893 Ethel Street, Kelowna, BC V1Y 2Z3

### SUBMITTING PART 1

Please fax **Part 1: Pre-Screening Application** to Bridgeway at:  
**1-236-766-5085**  
 Pages 3-9 must be typed, Page 10 must be printed and signed.

If also applying for **Supported Recovery** post treatment, please indicate your preferred location:

Kelowna     Penticton     No preference

*If applying to Supported Recovery only, please complete separate application found on our website:  
[www.thebridgeservices.ca](http://www.thebridgeservices.ca)*

### CHECKLIST

#### Part 1: Pre-Screening Application

**Section A-F:** To be completed by Referral Agent, member of the applicant's community-based Substance Use Treatment Team (e.g. Substance Use Counsellor, MHSU worker, Private Counsellor etc.) in collaboration with the applicant to determine suitability for the Bridgeway Treatment Program and ensure the applicant meets criteria before completing Part 2.

- Section A: Criteria & Instructions
- Section B: Applicant Basic Information
- Section C: Referral Agent Information & Narrative
- Section D: Applicant Information & Narrative (Self-Reported)
- Section E: Signatures & Supplementary Package for Applicant
- Section F: Next Steps

*Bridgeway will contact the Referral Agent at the email provided with the outcome of the Pre-Screening Application. If a conditional acceptance is offered to the applicant, Part 2 of the application will be provided to the Referral Agent and Applicant to complete.*

### SECTION A – CRITERIA & INSTRUCTIONS

#### Inclusion Criteria:

1. Men, Women, Transgendered, Non-binary, Two Spirited aged 19 years and older
2. Recent or ongoing engagement in problematic substance use that has impacted and continues to impact many areas of their life such as physical health, mental health, family, vocation, relationships, etc.

3. Priority will be given to applicants that reside in communities that fall within the boundaries of the Interior Health Region. Only if space remains available will referrals from outside of the Interior Health Region be considered.
4. Considerations will be made for individuals who have limited access to resources and/or people in rural/remote communities.

### Requirements:

1. **Manage Activities of Daily Living** – Personal hygiene/grooming, bathing/showering, toileting, dressing, chores, medication management.
2. **Mobility** – Able to get self to and from different rooms of building, in and out of bed, in and out of accessible shower, self-serve buffet style meals.

3. **Full Participation**

**All participants coming to this program must be able to:**

- Join all programming from 9am – 7pm daily.
  - Work in a classroom-like setting where reading and writing is required.
  - Follow and honor group agreements and expectations.
  - Sit for 1-1.5 hours in programming at a time
  - Look at screens for 1-2 hours at a time.
  - Read handouts and literature provided & able to write short sentences for assignments.
  - Engage in a meaningful way in group therapy, individual counselling, and group workshops.
  - Accept direction and feedback from staff and other participants
4. **Well managed physical and mental health** – Medical appointments and/or accommodations should not interfere with applicants' ability to fully participate in the program. Applicants must have an ability to remain on site and participate without interference from pain resulting from health concerns (*e.g. tooth pain*) or experience negative impacts from unmanaged mental health (*e.g. ability to sustain focus throughout group therapy*).
  5. **Legal** – If you have upcoming court dates/probation or parole obligations they must not interfere with programming.
  6. **Cannabis** – Bridgeway does not accept applicants whose only problematic substance use is Cannabis nor is cannabis permitted on site.
  7. **Community Living and Independence** – Ability to cohabit with up to 19 other participants with limited private and dedicated quiet spaces. Ability and willingness to attend appointments, go to store, complete chores, clean room without staff support.

### Expectations of Referral Agent / Community Team:

1. The applicant is expected to have accessed the mental health and substance use supports that are available in their home community prior to considering a Facility Based Treatment option.
2. Referral must be made by a member of the applicant's community-based Substance Use Treatment Team (*e.g. Substance Use Counsellor, MHSU worker, Private Counsellor etc.*) in collaboration with the applicant.
3. Referral Agent and the applicant's community-based Substance Use Treatment Team are expected to continue providing support to the applicant during their attendance of the program. This includes at midpoint; for aftercare conferences; and as needed by the Bridgeway treatment team.
4. Referral agents are expected to participate in a transitional aftercare planning conference during the last week of the program with the applicant and Bridgeway clinical counsellor.
5. Referrals from correctional facilities must have a release date. Applications without a release date will not be accepted.

### Instructions for the Application:

Please consider the following tips when completing the application to ensure all the necessary information is provided:

1. If a portion of the application is left blank, please provide an explanation as to why. Otherwise, this will cause delay in the application process.
2. Applications must be typed (Page 3-9) and signed (Page 10)
3. Handwritten applications will not be accepted.
4. Once completed please fax to 1-236-766-5085.
5. The Bridge will contact you once your application has been reviewed.

**SECTION B – APPLICANT BASIC INFORMATION**

First Name:	Last name:	Pronoun(s):
Date of Birth (YYYY/MM/DD):		Home Community:

**SECTION C – REFERRAL AGENT INFORMATION & NARRATIVE**

Referral Date:	Organization:	Address:
Health Region: Interior Health <input type="checkbox"/> Northern Health <input type="checkbox"/> Island Health <input type="checkbox"/> Fraser Health <input type="checkbox"/> Provincial Health <input type="checkbox"/> Vancouver Coastal Health <input type="checkbox"/> Providence Health <input type="checkbox"/> First Nations Health Authority <input type="checkbox"/>		
Referral Agent Name:	Role/Title:	
Phone Number:	Email:	Fax:

**Additional Professional Support**

Profession	Name	Phone Number	Email Address	Support Provided

**Please describe the in-person day programming provided at your clinic/office**

Programs Provided		Check all that apply	Has your applicant attended? Yes/No	How many in-person sessions have been attended in the last 6 months?
1.	Individual clinical counselling	<input type="checkbox"/>		
2.	Group counselling	<input type="checkbox"/>		
3.	Day treatment program	<input type="checkbox"/>		
4.	Relapse prevention group	<input type="checkbox"/>		
5.	Skills groups – in person	<input type="checkbox"/>		
6.	Skills groups - online	<input type="checkbox"/>		
7.	Peer based support (e.g. SMART, NA, AA)	<input type="checkbox"/>		
8.	Other: _____	<input type="checkbox"/>		

If the applicant has not attended any of the above programming your office provides, please give an explanation as to why:

**Determination of Readiness for Treatment and Assurance of Continuity of Care**

What will the Referral Agent and community support team do to continue supporting their client during their time in treatment? (e.g. Available for phone calls, exploring post-treatment housing, attending care conferences, etc.)

Will there be supportive services available after transition back to community? (e.g. AA, Relapse Prevention, ongoing counselling etc). Please describe availability and plans.

What are the applicant's treatment goals and how can they be best supported?

Is this applicant independent with appointment attendance? If not, what support is needed?

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

**Mental Health**

Does the applicant have a diagnosed/undiagnosed mental health condition?

Yes  No

Please explain how this may impact their ability to attend and participate in group/live in a communal setting.

Are they stabilized on medication? Could this medication have side effects that impacts this person's ability to engage in programming?

How has their substance use impacted their mental health?

**Physical Health**

Please describe any chronic or persistent medical conditions, concerns, or mobility limitations the client has that could interfere with their ability to fully participate in programming:

**Substance Use**

What has this person done to address their substance use? (e.g. medication, peer support groups, Community substance use groups, previous day/facility-based treatment, harm reduction, detox).

How does this applicant's substance use impact their daily life?

**History of substance use concerns**

<b>Substance</b>	<b>Method of Use (Inject, smoke, snort, ingest)</b>	<b>Date last used (DD/MM/YYYY)</b>	<b># Days of use in last 30 days</b>	<b>Typical amount/quantity used daily</b>	<b>Age at first use</b>
Alcohol					
Non-beverage Alcohol (mouthwash/other)					
Tobacco					
Cannabis/cannabis derivatives					
Crack Cocaine					
Cocaine					
Heroin					
Fentanyl					
Non Prescribed or Misused Opioids					
Non Prescribed or Misused Benzos					
Crystal Meth					
Amphetamines					
Hallucinogens					
Inhalants					
Steroids					
Other					

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			
Psychosocial Factors			
Where and with whom can this applicant find support in their community? (e.g. family, friends, community services and professionals).			
What are the current/previous gaps in psychosocial support (e.g. housing/finances, relationships, spiritual/ cultural identity and engagement, gender identity/expression).			
Legal History			
What legal matters may impact the applicant's ability to attend the program? (e.g. court dates, pending charges, incarceration, ankle monitor, probation orders etc.).			
Does the applicant have a history of violence in any healthcare settings, correctional centres, or the community? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide information regarding these offence(s):			
Does the applicant have an AGG Alert or Purple Dot on their file? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Group/Communal Living Experience**

What group learning/engagement has this applicant had experience with previously/currently. (e.g. classroom learning, college/trade school, support groups, relapse prevention group, day/facility-based treatment).

Applicants may be sharing a room and will be expected to participate in group therapy, participate in educational groups, and complete chores during their stay. Applicants will live in a communal space with up to 19 other people. Please explain how you feel this environment will positively or negatively impact this applicant's recovery:

**Risk Assessment**

Please explain any previous or current risks this applicant may be experiencing (e.g. experience of overdose, self-harm, suicidal ideation or attempt previously or ongoing, risk of aggression/violence and verbal aggression).

Please provide detail on each risk factor identified: (e.g. lethality of suicide attempt, duration/frequency/severity suicidal ideation, overdose, self-harm etc.).

Please describe how the risk can be mitigated and ways the Referral Agent /community team will support:

**Recommendations**

Please note any specific needs your client may have or information you believe is important for us to know if they were to be accepted to Bridgeway:

**Current Housing**

<p><u>Housing Type:</u></p> <input type="checkbox"/> Own home/rental <input type="checkbox"/> Shelter <input type="checkbox"/> No Fixed Address <input type="checkbox"/> Subsidized housing <input type="checkbox"/> With Family/Friend <input type="checkbox"/> Other: _____	<p><u>Stable:</u></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will the housing be maintained and available for the applicant if they are <b>unable to complete the program</b>?</p> <p style="text-align: center;"><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p>Does the applicant want to return to this housing if they complete treatment?</p> <p style="text-align: center;"><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p><u>Safe:</u></p> <input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION D – APPLICANT INFORMATION & NARRATIVE**  
**Applicant Self-Reporting (With Clinician Support)**

Applicant Name:

Self-Identified Gender (*Select all that apply*):

Female  Male  Transgender  Non-Binary  Two-Spirit  Questioning  My Gender is \_\_\_\_\_

*If you identify as Transgender, Non-Binary, or Two-Spirit, please select which cohort you would prefer to stay within:*

Female  Male

Do you identify as an Indigenous Person?

Indigenous  Non-Indigenous  Unknown  Prefer not to answer

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:

What are you hoping to get out of coming to treatment?

What experience of group-based learning do you have? (*e.g. classroom learning, education groups, support groups, therapy groups, college learning etc.*).

At Bridgeway, you will live in close quarters with up to 19 other individuals, sharing a bathroom, completing daily chores, and possibly sharing a bedroom with one other person? Please share any concerns you have with this:

How do you resolve disagreements and receive feedback from others?

What types of support will be helpful or beneficial during your time in treatment? Are there any specific supports you are hoping to receive?

In what ways is your substance use impacting your life? (Housing, health, relationships, financial, etc.)



Any preferences for your stay?

### Brain Injuries Assessment

1. Have you ever been injured by a blow to the head?  Yes  No

2. Have you ever lost consciousness following a blow to the head?  Yes  No

MVA  Assault  Weapon  Other      Date(s): \_\_\_\_\_

Explanation as appropriate:

3. Are you aware of any overdose events where you experienced a prolonged period of loss of consciousness and/or stopped breathing?  Yes  No

**As a result of a blow to the head or overdose, do you experience any of these symptoms:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Change in mood             | <input type="checkbox"/> Difficulty looking at screens | <input type="checkbox"/> Mood swings          |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Poor problem solving       | <input type="checkbox"/> Sensitivity to sound          | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Difficulty remembering   | <input type="checkbox"/> Difficulty reading/writing | <input type="checkbox"/> Sleep issues                  | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Changes in personality   | <input type="checkbox"/> Other: _____               |  |   |

Please explain how the symptoms selected impact your daily life and how you manage them:

What do you currently do to manage these symptoms?

How might these symptoms cause issues/discomfort for you during your time at treatment?

### Pregnancy Information

Pregnant:  Yes  No  Unknown

Anticipated Due Date: \_\_\_\_\_

*If yes, additional information will be requested in Part 2 of the application if applicant is provided conditional acceptance to the program.*

**SECTION E - SIGNATURES & SUPPLEMENTAL INFORMATION PACKAGE FOR APPLICANT**

Please download, print and provide the Supplemental Information Package to the Applicant.

<b>APPLICANT SIGNATURE</b>	
<b>REFERRAL AGENT SIGNATURE</b>	

**SECTION F - NEXT STEPS**

Please fax **Part 1: Pre-Screening Application** to Bridgeway at:

**1-236-766-5085**

Pages 3-9 must be typed, Page 10 must be printed and signed.

To address the potential barrier of access to a nurse practitioner or doctor, please find the medial portion of Part 2 on our website.

*Note: completion of medical portion prior to approval of Part1 is not mandatory*

**Application Acceptance**

Once you have received a Conditional Acceptance Letter from the Bridgeway Intake Team, you will be provided with Part 2 of the Application Package.

**Application Decline**

If the application is declined, you can expect to receive a letter from The Bridge which will explain the rationale, provide some alternative resources and may provide consultation as requested.

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