

Returning to
the Circle ~
Grandmothers
Aunties &
Caregivers
Program
Application Package

We are pleased to be a part of your healing journey.



Returning to the Circle ~ Grandmothers, Aunties & Caregivers Application Package

“Returning to the Circle”- Grandmothers, Aunties and Caregivers-July 18-28, 2021

COST: FREE

This ten-day program will explore the traditional Indigenous roles of Women in our families and communities. Programming will address multi-generational trauma stemming from the Residential School Legacy. This program will offer a safe space to begin looking at delayed grief and specific traumas (the roots of addiction) through experiential and cognitive processes using culturally relevant approaches.

Participants are asked to refrain from any and all drug and alcohol use during programming. Healing will be based on Traditional culture and ceremony- participants’ need to have a clear mind and spirit to connect with the Creator and Ancestors.

All those participating in, “Returning to the Circle” ~ Grandmothers, Aunties and Caregivers, will be sharing their accommodations with others if one has received the COVID-19 vaccine. Kackaamin has 2 bedroom, 3 bedroom, 4 bedroom, 5 bedroom and wheel chair accessible townhouse units. Each unit has one queen bed, and depending on the other units they have twin beds, with bathrooms and full kitchens.

Participants will be confirmed once applications are reviewed by our clinical intake committee.

CELL PHONE USE DURING PROGRAMMING WILL NOT BE TOLERATED.

Please note we are not accepting children or youth for this program due to healing demands of heavy programming, need for self-care of participants and COVID-19.

Kackaamin Family Development Centre Program Guidelines

- Clients must have a minimum 3 weeks of abstinence from any previously misuse substance.
- Smoking is allowed in the designated smoking areas
- Clients are responsible for their own travel arrangements to and from the center
- Arrival time on intake day is between 12:00 pm – 5:00 pm

Please connect with Intake Coordinator, Jenni Chase, at 250-723-7789 or jenni.c@kackaamin.org for appropriate applications for summer programming, and for any questions or concerns related to programming application requirements.

Grandmother's Aunties & Caregivers Application for 2021

PLEASE PRINT CLEARLY

IDENTIFYING INFORMATION

LAST NAME		FIRST NAME		KNOWN AS	
DATE OF BIRTH (YYYY MON DD)		<input type="checkbox"/> MALE	TELEPHONE		EMAIL
		<input type="checkbox"/> FEMALE			
ADDRESS			CITY	PROVINCE	POSTAL CODE
ABORIGINAL ANCESTRY		BAND NAME			ON RESERVE
<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO
CARE CARD NUMBER			STATUS NUMBER (10 DIGIT NUMBER)		

PERSONAL HISTORY

EMPLOYMENT STATUS		MARITAL STATUS:			
<input type="checkbox"/> WORKING <input type="checkbox"/> S.A. <input type="checkbox"/> E.I.C. <input type="checkbox"/> OTHER		<input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED			
Are you a survivor of Residential School? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Are you a survivor of a Day School Program? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Are you an Intergenerational Survivor of Residential/ Day School? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Substance Use History- Please Indicate Drugs of Choice and Date of Last Use: (We are collecting this information for program development and client safety while here)					
<input type="checkbox"/> ALCOHOL		<input type="checkbox"/> NON- PRESCRIPTION DRUGS		<input type="checkbox"/> PRESCRIPTION DRUGS	
Date of Last Use:		Date of Last Use:			
				<input type="checkbox"/> INHALANTS	
ii) Abuse Pattern		<input type="checkbox"/> DAILY <input type="checkbox"/> MOSTLY WEEK-ENDS <input type="checkbox"/> BINGE			

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT SURNAME		EMERGENCY CONTACT FIRST NAME		RELATIONSHIP
TELEPHONE		EMAIL		CITY OF RESIDENCE

INFORMATION

Do you have physical limitations that prevent you from doing recreational or cultural activities	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you require a wheel chair accessible unit?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any allergies (food, insect, medications) we need to be aware of		Please explain	
I understand and accept I will be placed in shared accommodation	<input type="checkbox"/> YES <input type="checkbox"/> NO	I am committed to complete a structured program process focused on my wellness	<input type="checkbox"/> YES <input type="checkbox"/> NO
I am willing to be involved in all types of intensive activities?	<input type="checkbox"/> YES <input type="checkbox"/> NO	I am willing to participate in First Nations Treatment program components such as sweat lodge, daily smudge, pipe and other cultural ceremonies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
I am willing to put aside all external distractions while in the journey to the wellness program	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you received the COVID-19 Vaccine?	<input type="checkbox"/> YES <input type="checkbox"/> NO

TREATMENT NEEDS

Have you engaged in healing programs (healing circle, cultural practice, etc.)?:

Trauma

Please note any recent or past traumatic events you feel comfortable disclosing at this time.

Specific Treatment

Please note any specific goals or needs (i.e. spiritual, mental, emotional, physical) that you have for treatment.

Specific Needs

Please note any special needs, physical limitations, or other concerns you may have at our Centre.

HEALTH HISTORY

LAST NAME

FIRST NAME

CARE CARD NUMBER

STATUS NUMBER (10 digit number)

Are you currently or have you ever been treated for any of the following? (Check All That Apply, or Non-Applicable)

- | | |
|---|--|
| <input type="radio"/> Asthma | <input type="radio"/> Varicose veins |
| <input type="radio"/> Bleeding disorder | <input type="radio"/> Pacemaker |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Musculoskeletal Problems |
| <input type="radio"/> Low Blood Pressure | <input type="radio"/> Cancer |
| <input type="radio"/> Headaches | <input type="radio"/> Pregnancy |
| <input type="radio"/> Diabetes | <input type="radio"/> Stroke |
| <input type="radio"/> Epilepsy | <input type="radio"/> Gastro-Intestinal Problems |
| <input type="radio"/> Heart Disease | <input type="radio"/> Hemophilia |
| <input type="radio"/> Arthritis | <input type="radio"/> Other (please specify): |

TUBERCULOSIS ~ **TB results must be attached**

DORMANT

(The patient must have had a T.B. Test in the last 12 months)

DATE

NOTE: If the skin test is positive and the results measure larger than 10mm, a subsequent TB chest X-ray must be performed.

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

MEDICATION NAME	CURRENT DOSE	TAKING SINE	PATIENT INTIALS	DATE FINISHED

Acknowledgment

I understand I am providing the following confidential medical information for my personal safety while at Kackaamin Family Development Centre, in case of a medical emergency

CLIENT SIGNATURE

DATE

REFFERAL WORKER NAME

REFFERAL WORKER PHONE:

REFFERAL WORKER SIGNATURE

DATE