In-House Program Application

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Mamisarvik Healing Centre

1071 Richmond Road, Ottawa, ON

T: 613-792-8132

F: 343-803-0209

Email: mhcintakes@tiontario.ca

Website: www.tiontario.ca

Disclaimer:

If full services in Inuktitut are needed, this program may not be the best fit right now, as services are not fully offered in Inuktitut.
However, speaking Inuktitut with others and expressing yourself in Inuktitut is always welcome. Staff will do their best to understand and support individual needs.

How to Complete This Application

We understand that completing applications can sometimes feel overwhelming. This guide will help you move through the process step by step. If you need support at any point, you are welcome to reach out for assistance.

Please note that missing medical or legal information may slow down the review process. Providing as much complete information as possible helps us process your application more smoothly.

Admission Criteria:

- 18 years of age or older
- Identify as Inuit
- Not currently on any withdrawal medication (methadone, suboxone, buprenorphine, etc.), prescribed opioids, benzodiazepines, or stimulants
- Willing to abide by house guidelines
- Motivation to heal

Referrals:

You can self-refer or be referred to by a support worker/outside organization.

Individuals applying from outside of Ontario will require a referral from a social service professional. Criteria for out-of-province admissions are outlined below the application steps.

Steps for Completing the Application:

Part I: Complete the Application Forms

☐ Fill out pages 4–9 of the application.

☐ Answer all questions as best as possible.

☐ If unsure about something, write that on the form.

If You Have Legal Involvement

☐ List lawyer's name and phone number (if applicable).

☐ List probation officer's name and phone number (if applicable).

☐ List bail supervisor's name and phone number (if applicable).

This helps staff understand legal responsibilities before the program begins.

Part II: Medical Portion

☐ Book an appointment with a doctor or nurse.

☐ Have the doctor or nurse complete the medical section and a TB test.

☐ Ask the doctor or nurse to fax the full application to Mamisarvik.

Make sure your NIHB number is included in the application to ensure medications and access to other health services are covered during your stay.

Part III: After Submitting the Application

☐ Watch for contact from the intake worker to book an intake interview.

☐ If no phone or email access, call Mamisarvik to confirm the application was received.

Intake Interview

☐ Complete the intake interview.

☐ Answer questions about substance use, mental health, and current situation.

☐ Ask questions if anything is unclear.

Part IV: Application Review

☐ Intake worker reviews the full application.

☐ Wait to be contacted about application status.

☐ A completed application does not mean you have been accepted. You will receive a formal acceptance letter if you have been accepted to our program.

Additional Information: Detox Requirements

Some individuals may need to complete detox before entering the program. If this applies to you, the intake worker will discuss your options to ensure transition into our program is as smooth as possible.

Out of Province

Mamisarvik Healing Centre welcomes Inuit participants from across Canada. If you are applying from outside of Ottawa, a few additional steps and requirements will apply to ensure safe travel, continuity of care, and coordinated support.

The following is needed:

☐ A referral from a social service worker including a short mental health summary.

- This should explain mental health history.
- It should explain current mental health needs.
- It should include a plan for ongoing care.

☐ A discharge and safety plan must be completed.

The discharge and safety plan must explain:

- A safe place where the person will go if leaving early.
- Who will be contacted for support.

If accepted:

☐ The referring worker must submit a medical travel request through NIHB or any agency that provides funding for travel.

Depending on location, medications may need to be brought in weekly blister packs for the full duration of stay.

Part I: Section A: Personal Information

PLEASE FILL OUT COMPLETELY

Date: _____

Full Name: _____

Date of Birth (DD/MM/YYYY): _____ **Age**: _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Two-spirit

☐ Other: _____

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Mailing Address:

_____

Postal Code: _____ **Phone:** _____

Permission to: ☐ Call ☐ Leave a voicemail ☐ Text

Email: _____

Inuit Nunangat Region: _____**Community:** _____

Non-Insured Health Benefits (NIHB) #: _____

Beneficiary #: _____

Health Card #: _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

Can we leave a message? ☐ Yes ☐ No

Identification of Referral Worker:

Name: _____

Phone: _____ **Email:** _____

Organization: _____

Section B: Current Situation and Support:

Languages spoken: _____

If Inuktitut, which dialect? _____

Source of Income: ☐ Employment ☐ Disability ☐ Social Assistance ☐ Other: _____

Housing:

☐ Securely Housed ☐ Couch surfing ☐ Shelters ☐Unhoused ☐ Other: _____

Do you need assistance finding safe housing? ☐ Yes ☐ No

Do you have a family member or friends that is currently employed with Tungasuvvingat Inuit? ☐ Yes ☐ No

Are you currently employed with Tungasuvvingat Inuit? ☐ Yes ☐ No

Please identify your immediate adult family members below:

Adult Family member name	Relationship	Age	Do you have contact with them?	Are they supportive of your treatment?	Do they abuse drugs or alcohol?

If you have children, please complete the information below:

Name of Child	Age	Who do they live with?

Are any of your children involved with the Children's Aid Society (CAS) or any other childcare welfare agencies? ☐ Yes ☐ No

If yes, please fill out the following:

Name of Childcare Service Worker: _____

Phone: _____ E-mail: _____

Are you connected with an indigenous child welfare organization? ☐ Yes ☐ No

If yes, who is your worker: _____

Is your attendance in treatment required by CAS or other childcare services? ☐Yes ☐ No

Section C: Legal

Is your attendance to treatment required by the legal system? ☐ Yes ☐ No

Have you ever been arrested? ☐ Yes ☐ No

Current Legal Status:

☐	On Probation	Until: _____
☐	On Parole	Until: _____
☐	On Bail	
☐	Residing in a Half-Way House:	Until: _____
☐	Inmate in Detention Centre	Until: _____
☐	Waiting Parole Board Decision	Date Schedule: _____
☐	Waiting for Trial/Sentence:	Date Schedule: _____
☐	Charges Pending	Court Date: _____
☐	Listed on the Sex Offender Registry	

Reason for conviction or charges leading to the above situations:

_____

_____

If applicable, provide a copy of your charges sheets and any conditions you may have

Probation/Parole Officer: _____

Phone: _____ E-mail: _____

Lawyer: _____

Phone: _____ E-mail: _____

Section D: Substance Use

Substances that you are currently using:

Substance	How many days a week do you use this substance?	How much do you use each sitting?	How long you have been using this substance

Do you think your substance use is problematic? ☐ Yes ☐ No ☐ Unsure

Section E: Mental Wellness

What are your strengths?

_____

_____

What kinds of situations, people, and experiences trigger strong emotional reactions for you? (People, loud noises, smells, etc.)

_____

_____

Many people who seek support have lived through difficult or painful experiences. Is there anything about your past that you would like us to be aware of so we can better support your healing journey?

_____

_____

_____

_____

_____

_____

_____

Section F: For Referral Worker

Please ask the applicant to sign a **Consent to Release Information form** and send us the following documentation when applicable:

- Official documents (such as Court Orders, Parole Board Decisions, Probation Orders, Decision Sheets, Temporary Absence Authorizations, etc.); and
- In cases of Parole/Probation/Bail/Youth Protection Measures, please provide information on condition(s) related to treatment. Since this is a co-ed facility, we need to ensure the safety of our vulnerable clientele.
- **If you are referring someone from outside of Ontario, please include a brief mental health assessment including mental health history, current mental health, and care plans (medication, counselling, etc.).**

Referral Worker's Comments and Recommendations about substance use, legal status, and overall well-being of applicant (In case of self-referral, please feel free to comment):

_____

_____

_____

_____

I recommend this client for Mamisarvik Healing Centre

Referral Worker's Signature: _____

Date: _____

By signing below, I confirm that the information I have shared is true to the best of my knowledge. I understand this form will be used to support my participation at Mamisarvik Healing Centre.

Client Signature: _____

Date: _____

Tungasuvvingat Inuit

CONSENT TO RELEASE INFORMATION

_____ born _____ (DD/MM/YYYY), hereby authorize a two-way release of information between Mamisarvik Healing Centre and the following individuals or agencies:

Agency / Service	Main contact name	Contact Information

You may include Elders, cultural counsellors, or traditional healers in the contact list, if applicable

For the purpose of (Reasons for Release):

- ☐ To coordinate services I am receiving
- ☐ To communicate relevant information about my current or past experiences that may support my care.
- ☐ I hereby agree to my information being saved in Mamisarvik electronic software

I have been informed, and I understand the nature of this consent. I have been informed that I may revoke my consent at any time by providing a written notice to the intake coordinator, which will be then placed in my file.

Participant Name: _____

Signature: _____

Date: _____

Mamisarvik Healing Centre
1071 Richmond Road Ottawa, ON
T: 613-792-8132
E-mail: mhcintakes@tiontario.ca

Part II: MEDICAL EXAMINATION
Must be completed by a Physician, RN, or Nurse Practitioner

PLEASE FILL OUT COMPLETELY IN CLEAR PRINT

Full Name of Patient: _____

Date of Birth (DD/MM/YYYY): _____

HEALTH CARD #:_____ **Exp.:** _____

Non-Insured Health Benefits Number (N########): _____

Date of Assessment: _____

Height (ft./in.): _____ **Weight (lbs):** _____

1. **Tuberculosis Test**
   The PPD result must be done within the last 6 months.
   If the PPD reading is higher than **20 mm**, we require a recent chest x-ray.

Test Type	Date	Results
TB Test		PPD:
Chest x-ray		

2. **This program involves participation in daily walks, outings, and various physical activities. Does the individual have the ability to engage in these activities**
   ☐ YES ☐ NO
   If not, please specify:
   _____
   _____

3. **Does the patient use a mobility device/cane to get around?** ☐ YES ☐ NO
   If yes, please specify:
   _____

4. **Is the patient experiencing current health problems?** ☐ YES ☐ NO
   If yes, please specify:

   _____

   _____

5. **Medical Diagnosis:**

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Asthma/COPD
- ☐ HIV/AIDS
- ☐ Hepatitis _____
- ☐ Head/Body Lice
- ☐ Scabies
- ☐ Tuberculosis
- ☐ Communicable Disease
- ☐ Cancer
- ☐ Pregnancy

How far along is pregnancy?

_____

- ☐ Hard of Hearing

Do they use hearing aids?

☐ YES ☐ NO

- ☐ Visually Impaired
- ☐ Other: _____

_____

6. **Does the individual have a cognitive, intellectual, or developmental disability?**
   ☐ YES ☐ NO
   If yes, please provide a brief description of the disability and any support or accommodations needed:

   _____

   _____

   _____

7. **Does the patient have any allergies?** ☐ YES ☐ NO
   If yes, please specify:

   _____

   Do they require an Epi-Pen? ☐ YES ☐ NO

8. **Does the patient have any dietary restrictions (lactose intolerant, no gluten, vegetarian, etc.)?** ☐ YES ☐ NO
   If yes, please specify:

   _____

   _____

9. Withdrawal difficulties

Please check off any symptoms the patient has experienced within the last 6 months as a result of substance use/withdrawal:

- ☐ Blackouts
- ☐ Auditory, visual or tactile hallucinations
- ☐ Shakes
- ☐ Irritability or agitation
- ☐ Irritability or agitation
- ☐ Cravings
- ☐ Nausea/vomiting
- ☐ Seizures
- ☐ Delerium Tremens
- ☐ Other:

_____

_____

10. Would you advise the patient to participate in a medically supervised withdrawal management program (detox)? ☐ YES ☐ NO

11. Has the individual experienced any accidental overdoses? ☐ YES ☐ NO

If yes, please specify how many and when the last one was:

_____

_____

12. Is the patient currently taking any medication? ☐ YES ☐ NO

If yes, please attach a medication list **(mandatory).**

13. Name of Pharmacy: _____

Address: _____ **Phone:** _____

14. History of self-harm

Has the individual ever engaged in self-harming behaviours or survived a suicide attempt? ☐ YES ☐ NO

If yes, when was the most recent instance?

_____

_____

15. **Mental Health History and Treatment:** Please provide a detailed account of any previous hospitalizations, diagnoses, treatments, and their outcomes. This includes recent mental health challenges, as well as any thoughts of self-harm or attempts (e.g., dates and methods).

_____

_____

_____

_____

_____

16. **Mental Health Care Professional(s) who is/are involved in working with the client.**

Name	Phone Number	Agency

17. **Would the individual like the Mamisarvik staff to collaborate with their existing mental health team during their stay?** ☐ YES ☐ NO

18. **Are there any upcoming medical appointments?** ☐ YES ☐ NO
    If yes, please complete the following table:

Appointment Date and Time	Location	Reason for Appointment

Comments or concerns from the individual conducting the assessment:

_____

_____

_____

_____

_____

_____

_____

_____

By signing below, I confirm that I am a licensed and qualified healthcare professional authorized to conduct medical assessments and complete this form. I affirm that the information provided in this medical examination is accurate, complete, and based on my professional evaluation of the individual named above.

Name: _____ **Signature:** _____

Title: _____ **Date:** _____

Telephone: _____

I, _____ , consent for my doctor's office, _____, and Mamisarvik Healing Centre to share relevant health and treatment information to support my care.

Signature of Patient: _____ **Date:** _____

Return to:

Mamisarvik Healing Centre
(613)-792-8132 ext. 3307 (intake)
Fax: (343)-803-0209
Email: mhcintakes@tiontario.ca