

Behavioural Health Foundation Inc. Youth Services



APPLICATION FOR ADMISSION

Accredited by the Commission on
Accreditation of Rehabilitation Facilities

Female Youth Program
35B ave. de la Digue
St. Norbert, MB. R3V 1L6
Phone 204-261-6111
Fax 204-275-2099

Male Youth Program
1147 Breezy Point Rd.
Selkirk, MB. R1A 2A7
Phone 204-482-9712
Fax 204-482-9717

Addiction and Co-occurring Mental Health Treatment Programs for Adolescents (12 to 17 years)



BEHAVIOURAL HEALTH FOUNDATION INC.

YOUTH SERVICES

Female Adolescents
Box 250, 35B ave de la Digue
St. Norbert, MB R3V 1L6
(204) 261-6111 phone
(204) 275-2099 fax

Male Adolescents
1147 Breezy Point Road
Selkirk, MB
(204) 482-9712 phone
(204) 482-9717 fax

Both locations are provincially licensed therapeutic communities of the Behavioural Health Foundation Inc. The youth programs provide long term, internationally accredited, residential programming for youths 12 – 17 years of age experiencing a variety of substance use and co-occurring mental health problems. Recognizing that addictions are symptomatic of cognitive, emotional and societal problems, the programs offer a safe structured environment with wholistic treatment. Emphasis is placed on promoting healthy living and assisting youth in making positive lifestyle choices.

Program Components

- Addictions counseling
- Integrated addictions and mental health treatment plans
- Group, family and individual counseling
- Aboriginal traditional activities
- Criminal Justice/Family Court Services
- Mental Health assessments, therapy and referrals
- Peer Mentor Program
- Links to primary health care
- Daily healthy living routines
- Work activities/employment readiness training
- Special Education Classrooms
- Literacy/Adult Education (as appropriate)
- Daycare for dependent children
- Outreach/graduate services
- Program evaluation and follow-up

Seminars/Courses

- ♦ Substance Use Awareness
- ♦ Family Violence Education
- ♦ Expressing and Managing Anger
- ♦ Assertiveness Training
- ♦ Life Skills
- ♦ Healthy Sexuality
- ♦ Taking Responsibility
- ♦ Coping with Grief and Loss
- ♦ Dealing with Abuse
- ♦ It's Not Your Fault¹
- ♦ Promoting Healthy Relationships¹
- ♦ Self Harm
- ♦ Bullying and Harassment
- ♦ Voices Journal²

www.bhf.ca

Programs Accredited by CARF, the Commission on Accreditation of Rehabilitation Facilities

¹ RespectED: Violence and Abuse Prevention, Canadian Red Cross

² Voices Interactive Journaling is developed by the Change Companies, and is registered in the U.S. Patent and Trademark Office



Behavioural Health Foundation Inc.
 35 ave de la Digue, Box 250, St. Norbert, MB R3V 1L6

APPLICATION FOR ADMISSION

Youth Services

SECTION A

Referring Agent's Name: _____

Agency: _____

Mailing Address: _____
 (Street Name & Number or P.O. Box #) Town/City (Province) (Postal Code)

Phone Number: _(_____)_____ Fax Number: _(_____)_____

After Hours Number: _(_____)_____ Email address: _____

Name of Youth: _____ Sex: Female _____ Male _____

Date of Birth: ____/____/____ Agency Status: ↓ Expiry Date: ↓
 Month Day Year

Band & Treaty # _____ V.P.A./C.C.A _____

DIAD # _____ Perm. Ward _____

MB. Medical Number: _____ (6 Digit) _____ (9 Digit)

Out of Province Medical Number: _____

Next of Kin: _____

Next of Kin Address: _____

Next of Kin Phone #: _____

SECTION B

1. What problem(s) is this youth experiencing at this time? Check all that apply:
- Alcohol use Duration _____
 - Alcohol use by a family member(s).
 (Specify relationship – mother, brother, sister, etc.) _____
 - Inhalant use Duration _____
 - Inhalant use by a family member(s).
 (Specify relationship – mother, brother, sister, etc.) _____

- Use of street drugs Duration _____
- Use of street drugs by a family member(s)
(Specify relationship – mother, brother, sister, etc.) _____
- Lack of education
- Lack of employment skills/training
- Involvement with the justice system
- Inappropriate social skills

2. How has substance use affected this youth's life? Check all that apply:

- Psychological well-being Physical well-being Family Situation
- Peer Functioning Educational Status

3. Does this youth have any on-going health issues or allergies? Yes No (If yes, explain)

4. Has this youth ever been given a mental health diagnosis by a qualified health professional or been hospitalized for a mental health related concern? (If yes, provide date of assessment and name of assessor). Please submit a copy of any existing assessments.

5. Is this youth currently taking any medication or taken any anti-depressant/anti-psychotic medications in the past? (If yes, please list)

6. Has this youth ever harmed self or thought of harming self but not as a direct result of alcohol/other drug use?

7. Does this youth have any history of attempted suicide, depression or mood swings? (If yes, explain)

8. What other treatment program has this youth attended? When? (If possible, please attach copies of any progress and/or discharge reports.)

_____ (Name of Facility) _____ (Date)

Reason for leaving treatment: _____

9.. History of abuse: (Specify physical, sexual, and emotional & the severity and/or duration).

10. Has this youth ever been charged with sexual assault or arson? (If yes, explain)

11. Please list past and/or current legal involvement/charges.

12. Is this youth currently on probation? Yes No Expiry Date: _____
If yes, provide name, address & phone number of contact.

Officer: _____

Address: _____

Phone #:_(_____)_____ Fax #:_(_____)_____

If applicable attach copy of conditions/court order

13. How much and what type of contact have you had with this youth? Are you willing to participate in the treatment process for this youth (i.e. progress meetings, visits, family counselling)?

14. Please insert a checkmark beside any areas of need that you feel are relevant to the youth being referred:

<p>Basic Routine:</p> <p><input type="checkbox"/> Punctuality</p> <p><input type="checkbox"/> Info-seeking</p> <p><input type="checkbox"/> Positive leisure activities/free time</p> <p><input type="checkbox"/> Cleanliness of living space</p> <p>Education/Employment:</p> <p><input type="checkbox"/> School</p> <p><input type="checkbox"/> Obtain Identification</p> <p><input type="checkbox"/> Employment Training</p> <p>Family/Peer Relationships:</p> <p><input type="checkbox"/> Family issues</p> <p><input type="checkbox"/> Issues of loss</p> <p><input type="checkbox"/> Communication skills</p> <p>Justice System Involvement:</p> <p><input type="checkbox"/> Attend court as required</p> <p><input type="checkbox"/> Abide by conditions</p>	<p>Physical/Mental Health:</p> <p><input type="checkbox"/> Personal hygiene</p> <p><input type="checkbox"/> Nutrition/eating habits</p> <p><input type="checkbox"/> Sleeping habits</p> <p><input type="checkbox"/> Medical issues</p> <p><input type="checkbox"/> Hearing</p> <p><input type="checkbox"/> Vision</p> <p><input type="checkbox"/> Speech</p> <p><input type="checkbox"/> Mental health issues</p> <p><input type="checkbox"/> Positive feelings about self</p> <p><input type="checkbox"/> Self-control</p> <p><input type="checkbox"/> Information on substance abuse</p> <p><input type="checkbox"/> Information on healthy sexuality</p> <p><input type="checkbox"/> Personal abuse issues</p> <p><input type="checkbox"/> Cultural/spiritual awareness</p> <p><input type="checkbox"/> Assistive Technology</p> <p><input type="checkbox"/> Advanced Directives</p> <p><input type="checkbox"/> Adjustment to disabilities/disorders</p>
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15. What type of supports would the youth have during and upon completion of residential treatment? (Example: social workers, NNADAP Workers, support groups, family members, school counsellors, etc.)

16. Identify an exit plan that will ensure continuous care of the youth should their placement at BHF become inappropriate. Provide contact information of the person responsible for transporting the youth.

Special exit instructions/protocols you would want followed:

17. Provide copy of Social History, if available,

18. Indicate who will be responsible for costs related to:

- a) Travel arrangements (upon admission and discharge): _____
 - b) Treatment program per diem: _____
 - c) Clothing needs of referral: _____
 - d) Travel arrangements for home visits: (As negotiated with referring worker) _____
 - e) Medical: dental, optical, therapy and prescription medications, transportation by ambulance
- _____
- _____

BHF Youth Services operate on a fee for service basis with some beds funded through a government agreement available for Manitobans who do not have the ability to pay. Fees for youth in the care of a child care agency are the responsibility of the referring agency, as set by the province of Manitoba. Written approval for funding of the per diem rate must be received in writing prior to placement for referrals attached to a child care agency. Out of province referrals are required to pay per day rates. BHF's Youth Services Placement Coordinator assists in providing information regarding funding/fees upon request.

FOR OUT OF COUNTRY REFERRALS ONLY:

Name of Health Care Provider: _____

Policy Name & Number: _____

FOR OFFICE USE ONLY!

Is this youth suitable for placement? YES _____ NO _____

If yes, accepted on what date? _____

Anticipated date of arrival: _____

If not, have recommendations been made for placement elsewhere?

Application reviewed by: _____ Date: _____