



Please put a ✓ in box beside the program you are applying for:

- Transitional Housing (THPGV)** 12520 140 Avenue, Edmonton AB T5X 5Z1
780-244-2962 fax 780-426-5392 ecoh.transitional@salvationarmy.ca
- Transitional Housing Downtown (THPDT)** 9304 103a Ave, Edmonton AB T5H 4R4 587-635-4486 fax
780-428-4407 ecoh.transitional@salvationarmy.ca
- Stabilization (SHP)** 12520 140 Avenue, Edmonton AB T5X 5Z1
780-244-2962 Ext. 131 ecoh.stabilization@salvationarmy.ca
- Keystone 2nd Stage Recovery (KEY)** 11830 85 Street, Edmonton AB T5B 3E9
780-490-6501 fax 780-477-2532 ecoh.keystone@salvationarmy.ca
- Cornerstone 2nd Stage Recovery (CORN)** 11838 82 Street, Edmonton AB T5B 2W2
780-474-7499 fax 780-474-4600 ecoh.cornerstone@salvationarmy.ca

EXCLUSIONARY CRITERIA (Not suitable for our programs.)

- Not identifying as the gender required by the program.
- Inability to pay for programming as set out for specific programs.
- Unsuitable for programming as determined by staff.
- Unsuitable for programming due to physical or mental health instability.
- Unsuitable due to mobility issues in programs that do not have proper accessibility.
- Unsuitable due to inability to attend to activities of daily living.
- Unsuitable for programming due to violence/aggression.
- Unsuitable for program due to balance owing or previous cessation of services.

The personal information collected through ECOH Salvation Army is for supporting provision of shelter and housing services to the participant. This collection is authorized by section 33 (c) of the Freedom of information and Protection of Privacy Act. For questions about the collection of personal information contact the Director of programs at 780.429.4274 by email at ecoh.info@salvationarmy.ca or mail to 12520 140 Ave Edmonton Alberta T5X 5Z1

Keystone/Cornerstone ONLY

This is a preliminary intake assessment, **not a confirmed bed**. This is the first step in the intake process.

1. Complete this (preliminary) intake package. *This is an intensive live-in recovery program.* (Call with any questions.) Sober living.
2. Receive a Step 2 Acceptance email or a telephone call and complete **telephone or virtual interview**. *You may be placed on a waitlist. Waitlists are managed by Acuity Scale.
3. Receive an intake date. Please arrive by 8:30 am on the date given. Some intakes can progress immediately based on beds available.

Conflict of interest statement : The Salvation Army and its staff are required to disclose or recuse themselves if there is a real or perceived conflict of interest.

ALL APPLICABLE SECTIONS IN THE APPLICATION MUST BE COMPLETED.

Please put a ✓ in box beside each line indicating you have read, understood, and agree:

ALL Housing Programs: Must meet all below criteria *and* program-specific section (A, B, C or D).

- Willing and able to participate in housekeeping duties.
- Must follow medication policy. Must agree to use ECOH partnering pharmacy.
- Agree to store all belongings in the assigned suite/bed/locker provided. All personal belongings must fit into the storage provided.
- Understand that garbage, food, weapons, pornography, alcohol/marijuana/illicit/illegal substances are not permitted and will be removed and disposed of.
- Consent to searches.
- Will participate in a smoking cessation program.
- Will fully participate in program; there are some mandatory components.
- Living arrangements may be shared and a new participant can be added without notice.
- Will be required to build, engage, and adhere to Transitional Plan while in program.
- Willing to abide by the program philosophy, policies, schedules, rules, and willing to participate in all program components which may include counseling, group work, class work, homework, spiritual/emotional care, physical activity, assessments, service opportunities (chores), care of client area, and all relevant activities scheduled by Program staff.

****All participants will be given the Participant Handbook for review with staff upon intake/orientation.***

A. TRANSITIONAL Housing Program

- Minimum age of 18 years.
- Willing and able to pay program fees.
- Shower/Intake procedure required.
- Visits in Dorm/Room are not allowed (including from other participants).
- I agree this is a time-limited program, focused on rehousing and community connection. I am willing and able to engage with staff to find suitable housing.
- I agree to leave my room as per scheduled cleaning requirements.
- I understand this program is a maximum of 18 months; my focus will be on a plan to complete my goals as quickly as possible.
- I will provide my own lock where required.
- Meals are *not* included; meals can be purchased. Snacks may be provided.
- Parking is not available. Vehicles will be towed.

B. STABILIZATION Housing Program

- Minimum age of 18 years.
- I agree to obtain approved passes for leaves and will sign in and out as per program requirements.
- Meals are included.
- Rapid short stay (14 DAYS) or determined by Transitional Plan.
- I agree to quiet time (curfews), which is 11:00pm to 5:00am.
- Parking is NOT available. Vehicles will be towed.
- I agree to medication administration. I will present myself to the medication room for prescribed medication at the times indicated and take medications in the presence of staff.

C. CORNERSTONE (Residential Recovery) Program

- Female/Identifies as female. Minimum age of 18 years.
- Has recently completed a residential substance dependence treatment program.
- Willing and able to pay program fees.
- I agree to quiet time (curfews), which is 11:00pm to 5:00am.
- I agree to live in sobriety; this is a sober living house with a focus on my recovery; I agree to random urine drug screen tests.**
- I understand that although this program is a maximum of 18 months, the focus is on a plan to complete my goals as quickly as possible.
- Parking: first come, first served; limited parking is available.

D. KEYSTONE (Residential Recovery) Program

- Male/Identifies as male. Minimum age of 18 years.
- Has recently completed a residential substance dependence treatment program.
- I agree to obtain approved passes for leaves and will sign in and out as per program requirements.
- I agree to quiet time (curfews), which is 11:00pm to 5:00am.
- I agree to live in sobriety; this is a sober living house with a focus on my recovery; I agree to random urine drug screen tests.**
- Food for meal prep is provided. Each suite is equipped with a kitchen.
- I understand that although this program is a maximum of 18 months, the focus is on a plan to complete my goals as quickly as possible.
- I agree to medication administration. I will present myself to the medication room for prescribed medication at the times indicated and take medications in the presence of staff.
- Parking: first come, first served; limited parking is available.

SECTION 2: PROGRAM SERVICE AGREEMENT (RULES)

Please take your time to read each point carefully and mark each box with a ✓ once you have read it.
Participant agrees to the following:

- I agree and understand the program does not fall under the Landlord and Tenancy Act.
- I agree I can be discharged at any time upon the sole discretion of The Salvation Army Edmonton Centre of Hope staff – without cause, without notice.
- I agree this is a scent-free environment.
- I agree to always be presentable (clean clothing/proper footwear) and in good hygiene.
- I agree no pets are allowed of any kind.
- I agree that visitors are not allowed.
- I agree that ECOH is not responsible for my belongings; anything I leave behind will be packed and disposed of within 72 hours of my departure.
- I agree to use only command type adhesives (no nails) to hang items on my walls.
- I agree not to borrow, steal, or sell any item or service while in the program.

- I agree to check in with staff once every 24hrs; failure to check in will require staff to seek me out during rounds, including nights.
- I agree that this is not a detox program, and substance abuse and intoxication are not permitted.
- I agree to not be behaviorally disruptive while on ECOH property.
- I agree to smoke only in the designated smoking areas.
- I agree to not tamper with any fire alarm/security system.
- I agree that I can manage my emotional state.
- I agree that if deemed by myself or staff that medical attention (for physical or mental distress) is required, I will be assessed and will not decline service.
- I agree that if I become deceased while in the program, my belongings will be released to the person I have identified or disposed of, as per policy.
- I agree that I will not have excess possessions including garbage or food. All items must be stored according to staff direction. *Regular checks without notice are performed.
- I consent to staff entry without notice or permission.
- I agree to not have or bring into the building ANY item considered: disrespectful, racist, dangerous, weapons or an item that is used as a weapon, pornographic, drug-related/paraphernalia, drugs/substances, alcohol.
- I agree to regularly meet with staff, to support me and to identify my goals while in the program.
- I agree that I am willing and able to complete the mandatory hours/classes/sessions in my program.
- I agree to provide documents requested by staff within 7 days of the request.
- I agree to treat all persons and property with respect – to not damage, abuse or intimidate.
- I agree to pay for damages caused by negligence or actions. Associated costs are outlined in the Participant Handbook.
- I agree that the Salvation Army is not liable for my property or for any actions by other participants within the programs.
- I agree to not add any furniture or appliances without written permission; these will be removed and disposed of without notice or replacement.
- I agree that all mail shall be delivered to the office area of the program.
- I agree that my key or fob cannot be copied. I will report a lost key/fob. I accept there is a replacement fee of \$5.00 for a key and \$15.00 for a fob. I agree to not install any additional locks or door locks. These will be cut immediately without notice.
- I agree to see the medical staff as required.

SECTION 3: PARTICIPANT INFORMATION

Complete the following in the spaces provided. If any information is not applicable indicate as NA. Please mark all questions.

GENERAL INFORMATION:

Bed Assigned: _____

First Name:		Last Name:		Nickname (or other name known by):	
Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/>		Age: <input type="text"/>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Provincial Health Card Number:
DD MM YYYY					
Phone Number:		If you do not have a phone number, how can we contact you?			
Language(s) Spoken:			Language(s) Understood:		
Status? <input type="checkbox"/> Yes <input type="checkbox"/> No	Band Name:			10-Digit Treaty Number:	
Emergency Contact:		Telephone:		Relationship:	
My belongings can be released to: Name:			Telephone:		<input type="checkbox"/> Same as above (Emergency contact)
Do you have any communicable diseases?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:		
Are you taking an (OAT) Opiate Agonist Replacement Therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:		
Family Doctor Name:			Clinic location:		
If prescriptions or an ambulance are required, how will it be paid for? <input type="checkbox"/> Alberta Works <input type="checkbox"/> AISH <input type="checkbox"/> Blue Cross <input type="checkbox"/> Health Canada (INAC) <input type="checkbox"/> Other: Account #: _____					

RELATIONSHIPS:

Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Common-Law	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	
Children / Dependents							
Name:	Gender:	Age:	Relationship:				
	<input type="checkbox"/> Male <input type="checkbox"/> Female						
	<input type="checkbox"/> Male <input type="checkbox"/> Female						
	<input type="checkbox"/> Male <input type="checkbox"/> Female						
Are you adopted, or did you spend time in foster care?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments:
Do you have any spiritual/religious beliefs?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments:

Supportive people in your life:

Are you under any of the following legal conditions?

Bail Parole House arrest / Need supervision for outings

Is a probation order attached?

Yes No I am on a registry Other (provide details, dates, etc)

Contact for legal issues: _____ Phone: _____

Role: _____ Email: _____

SUBSTANCE(S) USED:

Substance of Choice:	Daily	Weekly	Monthly	Other helpful information:
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

WITHDRAWAL AFFECTS:

Symptoms:		Comments:
Blackouts, seizures, hallucinations, DT's, or violence.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Days substance-free:		
Did you attend detox?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PROCESS CHALLENGES:

Process/Behavioral/Emotional Struggles:		Comments:
Gambling, eating, sex, grief/loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TREATMENT HISTORY:

Have you been to a residential treatment program before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How did you maintain your sobriety?			
If YES, please provide information on your previous treatment experiences:			
Year	Treatment Centre	Substance	Completed
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:			
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:			
Describe your reason(s) for currently requesting to enter the program:			
The most important "goal for you right now" is:			

* All programs are housing and recovery focused transitional programs.

HEALTH:

Have you been diagnosed with mental/medical illness(es)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is medical documentation attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently on psychiatric medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe medication:		
Are you taking medication consistently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:		
Previous suicide attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when? Comments:		
Medical Issues:				
Medications currently prescribed:				

OTHER NEEDS:

Provide information about other issues and needs.

Describe other significant issues we need to be aware of (reading, writing, hearing, vision, ability to sit or stand for periods, recently hospitalized, chronic or brain injury, dysregulation of emotions):

Referral Worker Name:	
Title:	
Agency:	
Telephone:	
Email:	
Will you continue to see the participant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature:	Date:

SECTION 5: SERVICES ECOH WILL PROVIDE

A. The ECOH will provide the following services to the extent that staff are available, reserving the right to add, change, and suspend the same without notice.

Counselling and support (including substance dependence and rehabilitative life skills) by the program staff (to the extent that trained staff are available).	Employment assistance programs.	Spiritual and emotional care.
Co-building of a Transitional Plan, reviewed and edited regularly with the staff and participant; goal setting.	Facilitated recovery groups (to the extent they are available).	Assessments as deemed appropriate
A mandatory number of supported hours of programming, such as classes and workshops; hours to be determined by program staff and participant	Outings or events (may be assigned as mandatory program events)	Co-ordination of community-based supports and outside support services.
Assistance with applications for government services and supports.		

Participant Agreement and Signature:

I authorize the documentation of my information for program purposes. I understand and accept the program as described. I understand failure to adhere or dishonest answers may result in me being discharged or denied intake to the program. I accept that this is an intensive program, requiring my engagement and willingness, with mandatory requirements, schedules and rules. I understand there are **no** extensions on credit or time of stay. I understand that counselling and therapeutic interventions may be a part of my program, and consent to same.

I understand that I will be held accountable to the agreements set out in this agreement, the ECOH Participant Handbook and the Transitional Plan. This is a binding agreement by my signature and that of the program staff.

By signing this agreement, I am *requesting a license to occupy a bed/unit to be used as part of my active participation in the program*. I understand this license may be revoked at anytime and agree with my signature that this will **not** constitute a tenancy under the Landlord and Tenancy Act.

I have been provided a copy of the ECOH Participant Handbook and have had my questions answered by staff.

I understand and agree that Stabilization Housing Program has an end date of 14 days or as determined by the transitional plan.

Date: _____ Participant Signature: _____

Date: _____ Program Staff (print name): _____

Staff Signature: _____

AUTHORIZATION TO RELEASE AND/OR OBTAIN CLIENT INFORMATION

The personal information collected through ECOH Salvation Army is for supporting provision of shelter and housing services to the participant. This collection is authorized by section 33 (c) of the Freedom of information and Protection of Privacy Act. For questions about the collection of personal information contact the Director of programs at 780.429.4274 by email at ecoh.info@salvationarmy.ca or mail to 12520 140 Ave Edmonton Alberta T5X 5Z1

I authorize the Salvation Army to share my personal information Service Providers and/or any persons or agencies acting on behalf of these organisations, who can contribute to my care. The information may be collected and shared with sources such as:

Federal, provincial, and municipal government departments * Healthcare *Police Specified service providers:

I **understand** the reasons for sharing this information as stated below.

I **understand** that I may revoke this authorization at any time by giving written notice to the Salvation Army office. I also understand that the withdrawal of my authorization to share information may result in a reduction of services being available to me. I understand

consent is voluntary; however, this may limit the ability of services to work together on my behalf.

I **understand** that I have the right to restrict what information may be shared and with whom, and this may affect the provision of care to me.

I also understand why I have been asked to disclose my individual identifying health information and have been informed of the risks and benefits of consenting, or refusing consent, to such disclosure.

I **understand** that by signing this form and joining this program I am **agreeing that recording is used in all public areas(in/outdoor)** of the property, may be stored, may be released to any of the above.

I **understand** that my information will be held securely on paper and on computer in compliance with the Freedom of Information and Protection of Privacy Act.

I **have made the following restrictions/limitations** (if applicable please list restrictions)

I, _____ authorize the Director or delegate of the
Participant's name / Guardian representing the participant

Salvation Army office to **release** and/or **obtain personal information** Statement of use – **Personal information that is collected will be used only for the purpose of providing counseling and intervention services. Service will be primarily delivered by service providers. Where services need to be delivered by extended service providers, information will only be disclosed to them with consent. Information will not be used for any other purpose, unless required by law, and will only be disclosed to external parties with the consent of the individual to whom it pertains.**

(Participant's name) First Middle Last

Participant/Guardian Signature

Effective date:

Witness/ Salvation Army Signature

Position

Staff print name

Consent removed date: _____ Signature _____

Staff Signature : _____

19.40F2