



Association Advocating for Women and Community

Incorporation Number S-32261

Olive's Branch Application (Correctional Institution Specific)

The Olive's Branch mission is to provide a safe and supportive space for individuals to continue through their unique journeys of healing and recovery to achieve a life of sobriety, wellness, and reintegration back into society. It is with this mission that we strive to create a community of harmony and growth with its participants.

Olive's branch is a diverse community of people who band together in support of one another.

Olive's Branch works in collaboration with various agencies throughout BC. Individuals who are currently in or have recently exited a detox centre, are exiting a correctional centre, are currently in or successfully completed a treatment program, or individuals who are currently struggling with an addiction and have a desire and will to be and remain sober are eligible to apply. We ask for a one-year commitment to the program so individuals can get the most out of this opportunity. Applicants' intent and desire to maintain sobriety will be gauged to determine program suitability.

Individuals must have full funding in place to begin program participation. This includes a security deposit of \$300.00, contents deposit of \$25.00 and the monthly program fee of \$625.00.

Disclosure for exclusion:

- Olive's Branch is NOT an accommodation to suit bail terms.
- Charges or Convictions of Murder / Violent Sex Offenses

GENERAL INFORMATION (Applicant must be referred by one of the support teams within the institution)

Applicant Name: _____ Date: _____

Contact Information: _____ Date of Birth: _____

Referring Institution: _____ Referral Team of Institution: _____

Name of person referring: _____ Referral Contact Information: _____

Emergency Contact Information: _____ Name of Contact: _____

Applicant Release Date: _____

Relationship of Contact: _____

Status Indian (Yes / No)

Band Name: _____

Gender: Male Female Transgender

Marital Status: Single Married Common-Law Widowed Separated Divorced

INTRODUCTORY

1. What do you know about Olive’s Branch? Do you know someone at our facility?

2. What are your reasons for applying for Olive’s Branch?

3. How do you believe that participating in Olive’s Branch will help you? Also are you willing to meet on a regular basis with Olive’s Branch staff regarding your sobriety?

4. Are there caseworkers, counselors, mental health staff, community transitional team, etc. involved in your care? If so, please list all individuals/teams.

5. What is your source of income?

<input type="checkbox"/> Ministry Assistance	<input type="checkbox"/> PWD	<input type="checkbox"/> Band	<input type="checkbox"/> Other
<input type="checkbox"/> Employment Insurance	<input type="checkbox"/> CPP Pension	<input type="checkbox"/> None	

If other, please describe: _____

LEGAL HISTORY

1. Do you currently or have you ever had any criminal charges and/or convictions for:

Arson Sex Offense Felony Drug Conviction and/or Violent Crimes

If yes to any of the above, please provide detailed information on the charge(s) and or conviction(s).

It is mandatory to disclose all charges and or convictions, complete with attaching details to application, for assessment of acceptance into program

2. What are your current charges/convictions? **** Submission of all criminal charges is mandatory for the process of acceptance to the program****

3. Are you aware of any current or expired warrants? If so, please explain.

4. Are you being released with specific stipulations? If yes, please provide details (i.e., no contact order, electronic monitoring anklet, etc.)?

****PLEASE ATTACH RELEASE PLANS TO APPLICATION SUBMISSION****

5. Do you have upcoming court dates, probation appointments, etc.? If yes, what are the dates (specify)?

MEDICAL & MENTAL HEALTH CARE HISTORY:

1. Primary Physician: _____ Phone: _____

Mental Health Physician: _____ Phone: _____

Do you want/need to re-establish care? _____

Date of last medical visit? _____

Reason: _____

2. Do you have any current or past thoughts of hurting yourself or others? If yes, please describe.

3. Do you have a history of trauma (e.g., violence, rape, accident, etc.)?

4. Do you have any history with Intimate Partner Violence?

5. Have you ever been diagnosed with a Mental Health Disorder(s)? If yes, please specify and give dates of diagnosis.

6. It is a requirement that all individuals who are accepted to participate in the Olive's Branch program have received their TB testing. Have you received a negative TB test? (Test valid for one year)

Yes When: _____ No

SOBRIETY HISTORY

1. Are you currently struggling with an addiction? If so, what is your substance of compulsion? How long have you been abstinent?

2. What situations cause you to use? What would help to prevent a relapse?

3. Have you ever had a period of sobriety? What was your longest length of sobriety? When?

4. Have you ever attended a treatment facility or participated in a sober living program before? If so, which one and could you please describe what did and did not work for you?

5. At this point and time how would you describe your perfect recovery model?

6. What efforts are you willing to take in order to accomplish your goals?

7. What are you willing to change or give up for your sobriety?

PROGRAMMING

1. Participating in all programming is mandatory, how comfortable are you in group settings as well as one on one settings?

2. Do you have any questions regarding the mandated programming?

3. Guests are permitted during designated times and in designated areas after initial 30 days in the program have been completed. Visitors must provide a piece of identification upon signing in. Do you have any concerns regarding the guest policy?

4. Are you currently participating in any life skills enhancement programs outside of the correctional facility? If yes, how long have you been participating in it? Please explain the program contents.

GENERAL

1. Do you have a spouse, or any other family/friend supports?

2. Do you have a vehicle? Is it in operative condition, registered and insured in your name?

3. Do you have any mobility restrictions or anything that could prevent you from maintaining the cleanliness of your space? If so, please describe.

4. What is something you enjoy doing but currently are unable to? (i.e., crafts, swimming etc.)

****In affixing my signature below, I agree that all information on this application is true to the best of my ability. ****

Name (Print): _____ Signature: _____

OFFICE USE ONLY

Move to intake: Yes No

Notes: _____

**CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
PRINCE GEORGE HOMELESSNESS INTERVENTION PROJECT (HIP)
INTEGRATED CARE MANAGEMENT**

HIP's goal is to assist chronically homeless individuals to access needed services using a team approach. To support you most effectively, HIP is seeking your consent to obtain, use and disclose your personal information.

I, _____
(first name) (initial) (last name)

Date of Birth: _____
(year) (month) (day)

Hereby authorize:

- Ministry of Social Development and Poverty Reduction
- Ministry of Public Safety and Solicitor General
- BC Housing
- Northern Health Authority-Mental Health and Addictions
- RCMP- Prince George
- AWAC – An Association Advocating for Women and Community
- Canadian Mental Health Association
- Carrier Sekani Family Services
- Central Interior Native Health Society
- Elizabeth Fry Society
- Prince George Native Friendship Society
- Prince George Nechako Aboriginal Employment & Training Association
- BC New Hope Recovery Society (Baldy Hughes)
- Forensic Psychiatric Services Commission
- Prince George Urban Aboriginal Justice Society
- Aboriginal Housing Society of Prince George
- Northern John Howard Society
- Phoenix Transition House Society
- Native Court Workers and Counselling Association of BC
- Ministry of Children and Family Development
- Community Living British Columbia
- Prince George Activator Society
- Correctional Services of Canada
- Hadih House, Carney Hill Neighbourhood Society
- Blue Pine Primary Health Care Clinic
- City of Prince George
- Family Physician (name) _____
- Other Agency(name) _____
- Individual(name) _____

The above-named agencies collect, use, and share specific and limited need-to-know personal information about me (including my photograph, social services, health, corrections, and law enforcement agency's information) that will be used to assist me to secure housing and to provide coordinated HIP services to me.

While I am a participant in the HIP Program my consent will expire no later than one year after signing. I can also withdraw my consent at any time by contacting my HIP Case Manager.

(Client's signature or person authorized to sign for client)

(Date)

(Witness) print name and sign

Agency

The personal information in this form is collected by HIP under s. 26 (c) of the *Freedom of Information and Protection of Privacy Act* and section 6 (2) of the *Personal Information Protection Act*. The personal information will be used to confirm your consent given above. Should you have any questions about the collection of this personal information please contact: HIP Integrated Care Coordinator at 250 562-6262