

Stella's Circle

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Application Form

EMMANUEL HOUSE

Referral Information	
Name of referral source:	Date of referral:
Agency/organization:	Telephone/Email:

Applicant Information	
Surname:	First Name:
Address:	Telephone:
	Email:
Date of Birth:	<input type="checkbox"/> male Marital Status: <input type="checkbox"/> female
Social Insurance #:	MCP #: Expiry:
Emergency Contact Name:	2 nd Emergency Contact Name:
Telephone/Email:	Telephone/Email:
Source of Income: <input type="checkbox"/> full-time employment <input type="checkbox"/> part-time employment <input type="checkbox"/> income support <input type="checkbox"/> employment insurance <input type="checkbox"/> disability <input type="checkbox"/> pension <input type="checkbox"/> other	

Applicant Eligibility Criteria
<i>applicants must meet all of the following criteria:</i>
<input type="checkbox"/> 18 years of age or older
<input type="checkbox"/> in agreement with this referral
<input type="checkbox"/> Able to participate in communal living and group therapy.

Emmanuel House

83 Cochrane Street, St. John's, NL A1C 3L7

Tel: 709.754.2072 Fax: 709.754.6447

Email: emmanuelhouse@stellascircle.ca

To help us better understand the needs of the applicant, please complete as much of the following assessment as possible.

ASSESSMENT INFORMATION

ACCOMMODATION STATUS *Please select one*

- Primary homelessness (e.g. living on the street)
- Secondary homelessness - informal accommodation arrangements (e.g. with friends)
- Secondary homelessness - Emergency or crisis accommodation
- Transitional housing (e.g. Community Correctional Centre]
- Long term stable housing (e.g. rental /own home or living with family)
- Custody/Prison (earliest release date _____)
- Treatment Centre (specify _____)
- Hospitalization (admission date _____) Voluntary Involuntary
- Long term unstable housing

Please specify:

EDUCATION & EMPLOYMENT HISTORY *Please select one*

- Incomplete grade school or high school
- Completed high school
- Post-secondary education
- No employment history
- Employment experience

Please specify:

HISTORY OF ENGAGEMENT WITH SERVICE/SUPPORT PROVIDERS *Please select one*

- Disengaged (e.g. has withdrawn from service providers and does not want support)
- Erratic (e.g. inconsistent or fluctuating engagement)
- Limited engagement (e.g. willing to engage with certain service providers or in relation to some issues)
- Engaged (e.g. willing to work with service providers)

LEVEL OF SOCIAL CONNECTION *Please select one*

A. **FAMILY:** applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behavior's)
- Disengaged (e.g. does not have contact with family)
- Erratic (e.g. maintains contact with family but level of connection fluctuates)
- Connected (e.g. has contact with family)

B. **FRIENDSHIPS:** applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behavior's)
- Disengaged (e.g. does not have a friend or friendship network)
- Erratic (e.g. has friends but level of connection fluctuates)
- Connected (e.g. has a supportive friendship or friendship network)

C. **COMMUNITY:** applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behavior's)
- Disengaged (e.g. does not engage with local community)
- Erratic (e.g. maintains contact with local community but level of connection fluctuates)
- Connected (e.g. can identify relationships with local community)

MENTAL, EMOTIONAL AND PHYSICAL HEALTH STATUS

A. **Psychiatric diagnosis** *Please select those that apply*

- | | |
|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> FASD |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Other | |

Please specify:

B. Mental health and emotional well-being *Please select one*

- Unstable (e.g. mental health and/or emotional wellbeing issues unmanaged and affecting day-to-day functioning)
- Poor (e.g. mental health and/or emotional wellbeing issues partially addressed but continue to affect day-to-day functioning.)
- Managed (e.g. mental health and/or emotional wellbeing issues assessed and being addressed.)

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C. Addictions: *current substance abuse or gambling*

- Never occasionally (*once per week or less*) often (*daily*)

Please select those that apply

- Alcohol
- Cannabis - hashish
- Hallucinogens (PCP, Ketamine, LSD, Ecstasy, Phillosybin)
- Stimulants:
- Cocaine Crack
 - Amphetamines Methamphetamines
 - Khat Ritalin
- Benzodiazepams (temazepam, barbiturates (e.g. Zopiclone))
- Opioid's (codeine, OxyContin, oxycodone, opium, opine, heroin)
- Gambling
- Methadone
- Currently on Methadone
 - Previously on Methadone
 - Waitlisted for Methadone

D. Physical health *Please select one*

- Unstable (*e.g. chronic health issues, unmanaged and impacting on day-to-day functioning.*)
- Poor (*e.g. chronic health issues not managed but do not impact on day-to-day functioning.*)
- Managed (*e.g. chronic health problems, diagnosed and being treated.*)
- Healthy (*no known chronic health problems*)
- Unknown

Please check any that apply

Chronic health problems

- Diabetes High blood pressure
- Respiratory illness (asthma, COPD, bronchitis)
- Hepatitis Arthritis Epilepsy
- Other:

Please specify:

Smoking: Yes No

Interested in cutting down or quitting? Yes No

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E. Child Abuse History *Please select any that apply*

- Physical Abuse
- Sexual Abuse
- Emotional Abuse

F. Life Skills

- Has self-care needs (cooking, hygiene, budgeting)
- Has recreation/leisure skills needs
- Has had OT assessment
- Requires OT assessment

HARM & SELF-HARM

A. Incidence of self-harm *Please select from one of the bolded categories then select a frequency below it*

- Previous attempts and/or ongoing high risk of suicide.
 - Frequent serious attempts
 - Occasional attempts (e.g. harms self in response to critical incidents or situations)
- Causes or is at risk of causing significant and repeated physical damage to self but not at risk of suicide
 - Frequent (e.g. on a day to day basis physically harms self)
 - Occasional (e.g. harms self often in response to critical incidents or situations)
- Engages in high-risk behavior (e.g. substance abuse, sex work)
 - Frequent (e.g. on a day to day basis engages in behavior which places self at risk)
 - Occasional (e.g. in response to critical incidents or situations)
- Does not self-harm

B. Incidence of Harm to Others *Please select from one of the bolded categories then select a frequency below it (include incidences that did not result in charges or convictions)*

- Causes or is at risk of causing significant harm to another/others
 - Frequent (e.g. on a regular basis i.e. more than once a month harms another/others)
 - Occasional (e.g. infrequent harm to others)
 - Partner Violence
- Does not harm others
- Has been harmed by others as an adult/ was a victim of violence

LEGAL ORDERS *Please select applicable orders*

- Long Term Supervision Order
- NCR (Not Criminally Responsible) and followed by the Federal Review Board
- Probation
- Parole
- No criminal convictions
- Other

Please specify:

INCIDENCE OF OFFENDING

Please select relevant categories; please provide copy of criminal record if available.

A. Previous probation orders for:

- Offences against the person (e.g. including sexual assault, assault)
- Offences against property (e.g. burglary and theft)
- Prior probation or conditional sentence orders

B. Current probation orders for:

- Offences against the person (e.g. including sexual assault, assault)
- Offences against property (e.g. burglary and theft)

C. Previous prison sentences for:

- Offences against the person (e.g. including sexual assault, assault)
- Offences against property (e.g. burglary and theft)

D. Current prison sentences for:

- Offences against the person (e.g. including sexual assault, assault)
- Offences against property (e.g. burglary and theft)

- Not known to offend

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TO BE COMPLETED BY APPLICANT

What do you know about the Emmanuel House Program?

Identify the problems you feel you need to work on:

What do you hope to learn at Emmanuel House that would make things different for you?

Applicant Name	
Signature	
Date	

MEDICAL HISTORY: TO BE COMPLETED BY PHYSICIAN

Applicant Name	
Physician Name	
Physician Signature	
Date	

Medical and/or psychiatric diagnosis:

Current prescribed medications:

Comments:

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