



Hope Lives Here

**Application Form**

**Emmanuel House**

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

**Tel: 709.754.2072 Fax: 709.754.6447**

**Email: [emmanuelhouse@StellasCircle.ca](mailto:emmanuelhouse@StellasCircle.ca)**

**Please Note: Emmanuel House is Scent Free**

<b>Applicant Information</b>	
Surname:	First Name:
Address:	Telephone:
	Can Message be left?      Yes                  No
	Email:
Date of Birth:	Gender:
Emergency Contact Name:	MCP#
Telephone:	MCP Expiry Date:
<b>Referral Information</b>	
Name of person making this referral:	Date of referral:
Agency/organization:	Telephone:
	Email:
<b>Applicant Eligibility Criteria</b>	
Applicants must meet all of the following criteria:	
• 18 years of age or older	
• in agreement with this referral	
• able to participate in communal living	
• able and willing to participate in group therapy	

**ACCOMMODATION STATUS** Please select one:

- Primary homelessness (e.g. living on the street)
- Secondary homelessness:
  - a) Informal accommodation arrangements (e.g. with friends)
  - b) 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 \_\_\_\_\_)
- Long term unstable housing

**Further  
Comments:**

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**Education & Employment History** Please select one:

- Highest grade achieved in grade school: \_\_\_\_\_
- Post-secondary
- No employment history
- Some employment experienced

**Further  
Comments:**

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**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- Disengaged (e.g. has withdrawn from service providers and does not want support)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)

Please identify service/health providers familiar with applicant:

Doctors: \_\_\_\_\_

Psychologists: \_\_\_\_\_

Social Workers: \_\_\_\_\_

Other: \_\_\_\_\_

**LEVEL OF SOCIAL CONNECTION** Please select one:

A. FAMILY: Applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behaviors)
- 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)

Further comments: \_\_\_\_\_

B. FRIENDSHIPS: Applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behaviors)
- 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)

Further Comments: \_\_\_\_\_

C. COMMUNITY: Applicant is...

- Socially excluded (e.g. exhibits challenging attitudes/behaviors)
- 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)

Further Comments: \_\_\_\_\_

**MENTAL, EMOTIONAL AND PHYSICAL HEALTH INFORMATION:**

A. Psychiatric diagnosis, Please select those that apply:

- |  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> Grief                           | <input type="checkbox"/> Depression       | <input type="checkbox"/> FASD  |
| <input type="checkbox"/> Anxiety Disorder                | <input type="checkbox"/> ADHD/ADD         | <input type="checkbox"/> PTSD  |
| <input type="checkbox"/> Schizophrenia                   | <input type="checkbox"/> Eating Disorder  | <input type="checkbox"/> OCD   |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Other |

Further Comments: \_\_\_\_\_

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.)

Other Comments: \_\_\_\_\_

**Substance Use History:**

Please indicate all substances used:

**Past:**

- Alcohol
- Benzodiazepine (e.g. Ativan)
- Cannabis – hashish
- Hallucinogens (e.g. LSD)
- Opioids (oxycodone, codeine, heroin)
- Stimulants (cocaine, crack, ritalin)
- Prescription Drugs
- Fentanyl
- Tobacco
- Other \_\_\_\_\_

**Current:**

- Alcohol
- Benzodiazepine (e.g. Ativan)
- Cannabis - hashish
- Hallucinogens (e.g. LSD)
- Opioids (oxycodone, codeine, heroin)
- Stimulants (cocaine, crack, ritalin)
- Prescription Drugs
- Fentanyl
- Tobacco
- Other \_\_\_\_\_

Date of Last Drug use \_\_\_\_\_

IV drug use history      Yes       No

No History of Substance abuse

**Treatment History:**

Type of Service:

Where, When and Duration:

- Residential or Inpatient \_\_\_\_\_
- Community Counselling \_\_\_\_\_
- Detox \_\_\_\_\_
- Methadone \_\_\_\_\_
- Suboxone \_\_\_\_\_
- 12 Steps / self help \_\_\_\_\_
- Other \_\_\_\_\_

**Gambling History**

Yes       No      Comments \_\_\_\_\_

**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 select any that apply:**

- Diabetes
- High Blood Pressure
- Respiratory (asthma, COPD, bronchitis)
- Hepatitis
- Arthritis
- Epilepsy
- Other \_\_\_\_\_

**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

**G. Harm & Self-Harm**

**A. Harmed by others as adult:**

- Physical Abuse
- Emotional Abuse
- Sexual Abuse

**B. Suicidal Thoughts / Attempts:**

- Previous attempts and / or ongoing high risk of suicide.

Date of last attempt? \_\_\_\_\_

Further Information or Comments:

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**C. Self-harm**

- Causes or is at risk of causing significant and repeated physical damage to self but not at risk of suicide.
- Engages in high-risk behavior (e.g. substance abuse, sex work)
- Does not self-harm

**D. Incidence of Harm to Others**

Please include incidences that did not result in charges or convictions

- Causes or is at risk of causing significant harm to another/others
- Does not harm others

**LEGAL ORDERS** Please select any applicable orders:

- Long Term Supervision Order
- NCR (Not Criminally Responsible) and followed by the Federal Review Board
- Probation
- Parole
- Other

Please specify:

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- No Criminal Convictions

**INCIDENCE OF OFFENDING**

Please select relevant categories:

**A. Previous Convictions for:**

- Offences against the person (e.g. assault)
- Offences against property (e.g. burglary and or theft)

Further information, regarding past or current probation or court orders:

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**B. Arson – Charges / Convictions:**

- Arson Charges
- Convictions

Please Specify: \_\_\_\_\_

**C. Sexual Assault – Charges / Convictions**

- Sexual Charges
- Convictions

Please Specify: \_\_\_\_\_

**D. Outstanding Charges**

- Please Specify: \_\_\_\_\_

**To Be Completed by the Applicant.**

What do you know about the Emmanuel House Program?

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Identify the problems you feel you need to work on:

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

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**Scented Products are NOT PERMITTED, at Emmanuel House for example: Perfumes, Hair Sprays, Body Sprays, Men's Scented Products.**

Applicant Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emmanuel House  
83 Cochrane Street, St. John's, NL A1C 3L7  
Tel: 709.754.2072 Fax: 709.754.644  
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**Medical History to be completed by a physician, nurse case manager or nurse practitioner.**

Applicant Name: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medical and/or psychiatric diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current prescribed medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the Patient compliant with Medications?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments:

Do you see any problems that would pose a barrier living communally or participating in group therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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