Hope Mission Recovery Program

Hope Mission is a not-for-profit social care agency founded in 1929 Edmonton, Alberta, Canada which exists to serve, strengthen and uplift men, women, youth and children through the life-changing gospel of Jesus Christ.

Women's Facility
9908 106 Avenue T5H 0N6, Edmonton AB
Wellspringintake@hopemission.com
780-422-2018 ext 252 or 780-453-3412

Men's Facility
10534 100 Street T5H 2R6, Edmonton AB
Breakout@hopemission.com
780-422-2018 ext 312

Hope Mission Recovery Programs are long term, 12 to 14 month abstinence faith-based program. We emphasize a holistic need for recovery. Our approach includes Biblically based case management/classes, motivational interviewing, trauma informed care, cognitive behavioral techniques, peer mentors and group discussions. Below are services that will be provided for clients are in our care:

- Living accommodations/basic furnishings and 3 meals and snacks each day
- Coordination with EI or Income support for program fees
- Subsidized fitness passes through YMCA
- Budget assistance
- On-site health center & psychiatrist
- Recovery, life skills and Bible classes Monday- Friday
- Weekly Case Management meetings
- Common areas, telephone available 8 am – 10pm and television available after class
- Individual Recovery Goals
- Medication distribution
- Regular drug and alcohol testing
- Work service/volunteer planning
- Daily cleaning duties
- Opportunity for aftercare housing
- Local church partnerships
- Community events: Trips to Brightwood Ranch (when available) and social outings.
- Adherence to the Client Handbook, subject to change at any time

CRITERIA FOR ADMISSION
Below are the terms and conditions to remain in program. If at any time you no longer agree with these conditions, your recovery program and accommodations may be terminated. If you agree, your initials are required next to each statement.

- Participants must be stable on medications and willing to comply with medication rules
- Participants must be physically, mentally and psychologically able to participate in gym, classes and group meetings.
- Participants must be able to wake by 6 AM

- Participants must be abstaining from drugs, alcohol, pornography, gambling, sexual relations and romantic relationships (including staff or any members of Hope Missions Recovery Community)

- Participants must be able to weekly requirements including up to 20 hours a week of work service
- Participants must agree to random room checks and purchase receipts
- Participants must participate in random drug and alcohol testing
- Participants must agree to a curfew or agreed upon curfew and provide a weekly calendar stating where I am going for approval by case manager
- Participants must be willing to accept personal responsibility for their own recovery and actions
- Participants must not be suicidal and not harm to themselves or others
- On medication if receiving hallucinations or paranoia
- All clients must be clean for 5 days. Detox can be accessed at AADAC/Spady or Hope Mission Shelter
- A client cannot be on any Benzodiazepines or the sleeping aids Zoplicone (Imovane) and Zoldidem (Ambien)
- A client understands that it is a long – term recovery program and willing to commit to 12 months of program.

ADMISSION PROCESS

1) Complete application package(both application forms and medical assessment)
2) Fax or email application package
3) Phone Admission Coordinator to set up an interview
4) Interview
5) Decision will be made for a participant's admission

Please email application package(applications and medical assessment) to the correct facility.

Hope Mission Recovery Programs have the right to deny an applicant if there is information that is withheld or false or if they do not fit criteria.

Hope Mission Recovery Program Application

Application Information

First name	Middle Name		Last Name
Substitute Decision Maker First Name:	Middle		Last name
Client date of Birth	Age	AHC	SIN
Nationality (circle one) **Caucasian** **African** **Asian** **Latin** **Metis** **First Nations**	**If YES to Status First Nations**		Grade Level Completed
	Brand Number		College/University Completed
	Treaty Number		Read and write in English? □ yes □ no
	Do you ordinarily live on Reserve? If yes, name of Reserve?		List any supports from community agencies
	How long have you lived off Reserve?		
Do you have a cell phone? □ yes □ no		Cell phone number:	
Probation/Parole □ yes(*please provide court papers) □ no	Explain		Probation Officer Name/Contact #
Outstanding Legal Issues (Civil, Criminal, Family) □ yes □ no	Explain		

Emergency Contacts/ Supports – Automatic Consent to Contact

Full Name	Phone Relationship	Address
Full Name	Phone Relationship	Address

Income

Check all that apply
SFI □ EI □ AISH □ CPP □ WCB □ GST □ Tax Refund □ Past Employment □ Other(explain) □

Date of last monies received	Amount/month	Social Worker	Phone

Addiction History

Check all that apply
□ Alcohol □ Marijuana □ Cocaine/Crack □ Opiate/Narcotics □ Speed/Meth □ Amphetamines □ Heroin/morphine/codeine □ PCP □ Benzodiazepines □ Barbiturates □ Methadone □ Propoxyphene □ Oxycodone/Hydrocodone □ Ecstasy □ Tranquilizers □ Sleeping pills □ Tobacco □ Coffee □ Porn/Sex □ Gambling □ TV □ Food □ Codependency □ Shoplifting

What is your primary addiction?	Length of Use	What is your secondary addiction?
Describe your recovery history(past treatment, longest recovery times, etc.)		
Date of last use	Substance used	What is your recovery plan?

Housing History

Have you experienced homelessness for one year or more prior to entering Wellspring? □ yes □ no

If no, have you experienced 4 or more periodic episode of being homeless during the last 3 years? □ yes □ no

Have you experienced domestic abuse in the last year? □ yes □ no

If yes, are you currently in a domestic abuse situation? □ yes □ no

Are you currently involved in a relationship with someone? □ yes □ no

Do you currently know of anyone in Breakout or Wellspring? □ yes □ no

If yes, what is the name of individual: _____

Medical History

Check all that currently applies

□ allergies □ arthritis □ asthma □ diabetes □ epilepsy □ ulcer □ stomach problems □ heart condition □ major injuries □ major surgeries □ alcohol seizures □ memory loss □ HIV □ TB □ Hep C □ other(please explain)

Family Doctor	Phone	Address

Are you currently under a doctor's care? If so, for what conditions?

Do you have any upcoming surgeries or procedures that would require you to take time off of program?

Psychological History

Check all that apply

□ depression □ anxiety/paranoia □ hallucinations □ mood swings □ panic attacks □ suicidal thoughts □ suicide attempts □ anger/violence (without drugs/alcohol) □ anger/violence with intoxicants □ psychiatric assessment in the past □ psychiatric hospitalization at any time □ psychiatric diagnosis □ Bi-polar □ OCD □ multiple personalities □ FASD □ ADHD □ memory loss □ PTSD □ BPD □ other

Psychiatrist/Therapist (if no, do you need to see a mental health worker?) Explain

Appointments	Phone/Contact

Client Consent to the Disclosure of Personal Information to Receive Outreach Support Services [1]

Name[2]: _____
(Print name of Individual)

Required Information[3]: _____
(Date of Birth) (Client ETO Number)

I hereby authorize[4] Hope Mission

to use and disclose my individually identifying personal information① from my client file to and between the service providers as specified below[5]

□ Homeward Trust

□ Hope Mission Staff Members

□ Rexall Pharmacy

□

□ Probation/Parole Officer

□ Income Support

□

□

I understand the reasons for the sharing and use of the information as described below, that my consent is voluntary, and that failure to provide consent will not result in any adverse decision about my rights, benefits or services, other than limiting the ability of the organizations to work together on my behalf.[6]

I also understand why I have been asked to disclose my individually identifying health information, and have been informed of the risks or benefits of consenting, or refusing to consent, to such disclosure. I further understand that I may revoke this consent at any time.[7]

Dated and effective as of _____ of _____, _____,[8]
(day) (month) (year)

_____ _____
Signature of Client[9] Print Client's Full Name

_____ _____
Signature of Witness[10] Print Witness's Full Name

Statement of Use[11]

Personal information that is collected will be used only for the purpose of providing counseling and intervention services. Services will be delivered primarily by the 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.

Authority[12]

Individually, the members derive their authority from the specific legislation that they operate under, or by virtue of being a program or activity of the governing organization in order to collect, use as well as to disclose client information to other integrated service providers on a need to know basis②

This consent will expire one (1) year after the client has ceased receiving services under this program.[13]

Medication Policy
Hope Mission Health Centre,
9908 106Ave Edmonton, Alberta T5H 0N6
Phone: 780-422-2018 ext. 278
Fax: 780-421-4522

The following medications are **ALLOWED** in the Hope Mission Programs:

ADHD	• Atomoxetine (Strattera) • Extended-release methylphenidate (Concerta; Biphentin)
Pain Medications	• Buprenorphine (BuTrans, Suboxone) • Methadone (Metadol)
Sleep Aids	• Amitriptyline (After working on Sleep Hygiene Tips)

The following medications are **NOT ALLOWED** in the Hope Mission Program:

Opioid Pain Medications • Codeine & Codeine-containing products (e.g. Tylenol #3) • Morphine (e.g. Kadian) • Fentanyl • Hydromorphone (Dilaudil) • Oxycodone (Percocet, OxyNeo) • Meperidine (Demerol) • Tapentadol (Nucynta) • Tramadol (Zytram, Ralivia, Tridural) • Pentazocine (Talwin) • Propoxyphene (Darvon)	**Benzodiazepines** • Alprazolam (Xanax) • Bromazepam (Lectopam) • Lorazepam (Ativan) • Oxazepam (Serax) • Temazepam (Restoril) • Triazolam (Halcion) • Chlordiazepoxide (Librium) • Clonazepam (Rivotril) • Clorazepate (Tranxene) • Diazepam (Valium) • Flurazepam (Dalmane) • Nitrazepam (Mogadon)
Psychostimulants • Dextroamphetamine (Dexedrine) • Amphetamine Mixed Salts (Adderall XR) • Lisdexamfetamine (Vyvanse) • Methylphenidate (Ritalin)	**Miscellaneous** • Nabilone (Cesamet) • Dronabinol (Marinol) • Medical Marijuana
Sleep Aids • Zopiclone (Imovane) • Zolpidem (Ambien or Sublinox	**NSAIDS** • Ibuprofen* • Naproxen*
Antidepressants and Antipsychotic: • Sertaline* • Trazodone	**Anticonvulsant and Antipsychotic** • Phenytoin (Dilantin)
Antipsychotic • Quetiapine	

(Note: This list is not exhaustive, and other medications may be subject to restriction)

Sertraline, Ibuprofen and Naproxen are still allowed in the Breakout Program

Alberta Health Services

Residential Adult Addiction Treatment Program Application

This medical assessment is required as part of the application and must be completed in full by a medical doctor or nurse practitioner. The cost of fully completing this medical is covered by Alberta Health Care.

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	Personal Health Care Number

Allergies *(e.g.drug, food, medical tape, other)*

Review of Systems *(please send relevant reports, e.g. CBC, hepatic profile, electrolytes, urinalysis, fasting blood glucose)*

EENT

Respiratory *(e.g. asthma, COPD)*	Cardiovascular *(e.g. CVA, MI, HTN, arrythmia, pacemaker)*
Gastrointestinal *(e.g. GERD, history GI bleed, hepatitis, pancreatitis)*	Genitourinary *(e.g. incontinence, BPH, STD)*
Musculoskeletal *(e.g. chronic pain, RA,OA, gout)*	Integumentary *(e.g. psoraiasis, eczema)*
Neurological Does the patient have a history of seizures? ☐ No ☐ Yes	Hematological/Immune *(e.g. HIV+, HCV+)*
Evidence of withdrawal or intoxication? *(e.g. ETHO, OPIOID)*	Other *(specify)*

Physical Examination

Height	Weight	Temperature	Pupils	Heart rate	Blood pressure	Respiration rate

Skin	Diaphoresis	Tremor

Is the patient diabetic? ☐ No ☐ Yes, complete this information ▶ *(need recent HbAlc result)*	Year diagnosed	Is the patient stable? ☐ No ☐ Yes
Does the patient have MRSA and wound? ☐ No ☐ Yes, *(specify latest swab results)* _____	Is there cognitive impairment? ☐ No ☐ Yes	

Needs assistance ambulating or providing self care? ☐ No ☐ Yes

Pregnancy

Is the patient pregnant?	LMP		Para	Gravida	
☐ No, complete top boxes only ▶ ☐ Yes, complete **all** boxes ▶	EDC	Urine hCG	Prenatal blood work	Prenatal ultrasound	Blood type

Does the patient have current pregnancy complications or had a history of pregnancy complications?
☐ No
☐ Yes, specify _____

Physician managing the pregnancy and delivery	Phone	Fax

Address of planned location of delivery

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	PHN

TB Screening - Symptoms and History

Check the appropriate boxes	**No**	**Yes**
Presence of cough lasting more than 2 weeks		
Weight loss, if yes specify ____ lbs. in _____ length of time		
Night Sweats		
Fever		
Fatigue		
Haemoptysis *(blood in sputum)*		
Previous active TB and treatment		
Previous significant Mantoux or chest x-ray results		
Extensive travel *(or birth)* in a country with high incidence of TB		
Other risk factors *(i.e. aboriginal, elderly, homeless, health care worker)*		
Poor general health status and risk factors for progress of disease		
Further TB screening/assessment required -if **yes** please send results to appropriate centre		

Medical Approval

In your opinion is this patient medically stable and appropriate for admission to Residential Addiction Treatment?

☐ No ☐ Yes

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Psychiatric Review/History *(send psychiatric evaluations and/or discharge summaries if available)*

Addictions-note date of last use, pattern of abuse and severity of addiction *(e.g. alcohol, cocaine, opioids, cannabis, gambling, tobacco, etc.)*

Primary	Secondary	Tertiary

Is there evidence of the following? *(please include your judgement related to current severity of mental health concerns)*

✓	**No**	**Yes**	**Comments**
Mental, developmental and/or learning disorders *(e.g. depression, anxiety disorder, bipolar disorder, ADHD, phobias, psychosis, schizophrenia)*			
Underlying pervasive or personality conditions *(e.g. personality disorders, mental retardation)*			
Acute medical conditions and physical disorders aggravating mental health *(e.g. brain injury, cognitive impairment, chronic pain, insomnia)*			
Contributing psychosocial and environmental factors.			
Global Assessment of Functioning _____			
Is there a history of self-harm, suicidal thoughts or suicide attempts? ***(If yes, pertinent psychiatric reports/assessments are required)***			

Psychological Approval

In your opinion is this patient psychologically stable and appropriate for admission to Residential Addiction Treatment? ☐ No ☐ Yes

Physician or Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Alberta Health Services

Residential Adult Addiction Treatment Program Application

Patient Name *(last, first, initial)*	Date of Birth *(yyyy-Mon-dd)*	PHN

Medications *(if more room is needed, attach list. Send relevent laboratory results e.g. current INR, Lithium or Phenytoin level(s))*

Medication	Dose	Route	Frequency	Reason given	Start date	End date	Prescribed by	Phone number

Please remind patient that in order to be admitted to Residential Adult Addictions Treatment Program, they need to:

- Be well enough to participate in the program and remain **alcohol and drug free for at least five days prior** to admission.
- Ensure any new medications not listed above have been pre-approved by Treatment Program nurse.
- Bring enough of their medications *(in the original packaging from the doctor or pharmacist)* for their time in treatment.
- If the patient's medical or psychological condition changes before their scheduled admission date they must contact the Treatment Program.

Physician/Nurse Practitioner's Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Mailing address			
City	Postal Code	Phone	Fax
Primary Physician Name *(if different than above)*		Phone	Fax
Other *(e.g. psychiatrist or other specialist relevant to this admission)*		Phone	Fax
Primary Care Network affiliation? ☐ No ☐ Yes, complete this information ▼			
Name		Address	

Physician Stamp

Hope Mission
9908-106th Ave NW
Edmonton, AB T5H 0N6
Phone: Breakout 780-422-2018(ext.312)
Wellspring 780-453-3412
Fax: 780-426-7507

Re:
DOB:
Clinic Adress:
Tel. No:
Fax. No:

To. Hope Mission Recovery Program

This letter is to confirm that _____ meets all Hope Mission Recovery Program's criteria.

(NAME OF PATIENT)

_____	_____	_____
(NAME OF PHYSICIAN)	*(SIGNATURE OF PHYSICIAN)*	*(DATE)*