AWAC
Association Advocating for Women and Community
Olive's Branch

Olive's Branch Application for Participation

1. Applicant Information

Full Name:	Date of Birth	Preferred Name/Pronouns

Current Address or Location	Phone/Email

2. Referral & Supports

Referring Agency (if applicable)	Contact Person	Phone/Email

A. How did you hear about Olive's Branch? Do you know anyone currently or previously in the program?

_____

B. Why are you applying to Olive's Branch at this time?

_____

C. How do you believe participation in Olive's Branch will support your recovery goals?

_____

Are you willing to meet regularly with staff regarding your progress and sobriety?
☐ Yes ☐ No ☐ Unsure

D. Please list any caseworkers, counsellors, or community professionals currently involved in your care:

_____

E. Source of income (check all that apply):
☐ Ministry Assistance ☐ PWD ☐ Employment ☐ Employment Insurance ☐ CPP ☐ None
☐ Other: _____

F. Do you have any current or past criminal charges or convictions?
☐ Yes ☐ No If yes, please describe briefly: _____

3. Sobriety & Recovery History

A. Are you currently struggling with substance use? If yes, what substances have been most challenging? How long have you been abstinent?

_____

B. What situations, feelings, or environments are most likely to trigger use? What helps you avoid relapse?

_____

_____

C. Have you had previous periods of sobriety? What was your longest period and what helped you succeed?

_____

D. Have you attended treatment or sober living before? If yes, where and what worked or didn't work for you?

_____

E. What does recovery look like to you right now? Describe your ideal support system or recovery plan.

_____

_____

F. What steps are you willing to take to achieve your recovery goals?

_____

G. What changes or sacrifices are you prepared to make to support your sobriety?

_____

4. Health & Medical

_____ _____

Primary Care Physician Phone

_____ _____

Mental Health Clinician (if applicable) Phone

_____ _____

Date of last medial visit Reason

Do you wish to re-establish medical or mental health care? ☐ Yes ☐ No

A. Have you ever experienced thoughts of harming yourself or others? ☐ Yes ☐ No If yes, please describe support or safety plans currently in place:

_____

B. Do you have a history of trauma (violence, accident, loss, etc.) that may affect your stay? ☐ Yes ☐ No If yes, are you currently receiving support or counselling?

_____

C. TB testing is required for program entry. Have you received a negative TB test within the past year? ☐ Yes ☐ No Date: _____

D. Please list your current prescribed medications:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Note Restricted Medication List
*****ALL SAFE SUPPLY MEDICATIONS ARE STRICTLY PROHIBITED*****

All Pain Medication containing Opiates:
Tylenol 1, 2,3,4, Demerol, Talwin, Fiorinal Plain or other, Percodan, Percocet, Tramadol, 222,282,292,692, Leritine, Dilaudid, Fentanyl, Morphine, etc.

Opioid Antagonist Therapy (OAT):
Kadian, Naltrexone

All Benzodiazepines:
Valium, Librium, Ativan, Lorazepam, Xanax, Clonazepam, etc.

All Sleeping Pills:
Dalmane, Restoril, Imovane, Halcion, etc.

All Muscle Relaxants:
Robaxisal, Robaxacet, Flexeril, etc.

Over the Counter Cold Medications:
Cough syrup with codeine, alcohol, and/or antihistamines
Sedating antihistamines like Gravol, Chlor-Tripolon, Dimetapp, etc.

5. Program Participation & Daily Living

A. Participating in programming is mandatory. How comfortable are you in group and one-on-one settings?
_____

B. Do you have any concerns about program expectations or guest policies?
_____

C. Are you currently employed or in school/training? ☐ Yes ☐ No If yes, describe your schedule and commitments:
_____

D. Do you have any family or friend supports you can rely on during your stay?

_____

E. Do you have a vehicle? ☐ Yes ☐ No If yes, is it insured and in working condition? ☐ Yes ☐ No

F. Do you have any mobility limitations or health concerns that may affect daily living or housekeeping tasks?

_____

G. What are some hobbies or activities you enjoy and hope to re-introduce into your life?

_____

H. What does commitment to recovery mean to you personally?

_____

6. Declaration & Signature

I declare that all information provided in this application is true and complete to the best of my knowledge. I understand that providing false or incomplete information may affect my eligibility for the Olive's Branch program.

_____	_____	_____
Applicant Name	Applicant Signature	Date

Office Use Only

☐ Moved to intake ☐ Not accepted

Staff Notes:

_____

_____

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL IMNFORMATION

Integrated Care & Housing Continuum Supports

AWAC's goal is to support individuals in achieving housing stability, safety, and recovery through a continuum of services, including emergency shelter, outreach, sober living, supportive housing and independent living programs. To support you most effectively, AWAC is requesting your consent to collect, use, and disclose personal information for the purpose of providing coordinated care and connecting you with community resources and supports.

I, _____ Date of Birth: _____

(First Name) (Initial) (Last Name) (Year) (Month) (Day)

Authorize AWAC to collect, use and disclose information with the following:

☐ Ministry of Social Development and Poverty Reduction
☐ BC Housing
☐ Northern Health Authority – Mental Health & Substance Use
☐ RCMP – Prince George Detachment
☐ Canadian Mental Health Association (CMHA)
☐ Central Interior Native Health Society
☐ Carrier Sekani Family Services
☐ Prince George Native Friendship Centre
☐ Aboriginal Housing Society of Prince George
☐ Prince George Nechako Aboriginal Employment & Training Association (PGNAETA)
☐ Phoenix Transition Society
☐ Elizabeth Fry Society
☐ John Howard Society (Northern BC)
☐ Community Living British Columbia
☐ Ministry of Children & Family Development
☐ City of Prince George
☐ Local Treatment or Recovery Programs (specify): _____
☐ Family Physician (name): _____
☐ Other Agency or Individual (name): _____

Purpose of Information Sharing

The above-named agencies and individuals are authorized to collect, use, and share specific and limited need-to-know personal information about me, including social, health, housing, and law enforcement information, for the purpose of:

- Supporting my participation in AWAC's housing and recovery programs.
- Coordinating case management and service delivery.
- Assisting me in securing and maintaining housing.
- Providing referrals and access to appropriate health, social, and community supports.
- Promoting my overall well-being and safety.

Duration and Revocation of Consent

This consent is valid while I am an active participant in AWAC programs and will expire no later than one (1) year from the date of signing. I understand that I may withdraw or amend my consent at any time by notifying AWAC staff in writing.

_____ _____

Client / Participant Signature: Date:

If signed by an authorized representative:

_____ _____

Name: Relationship:

_____ _____

Witness Signature Agency & Position

Privacy Notice

The personal information collected on this form is collected under Section 26(c) of the Freedom of Information and Protection of Privacy Act (FOIPPA) and Section 6(2) of the Personal Information Protection Act (PIPA). This information will be used solely for the purposes identified above.

If you have any questions regarding the collection, use, or disclosure of this information, please contact: Executive Director – Association Advocating for Women and Community (AWAC) 144 George Street, Prince George, BC Tel: (250) 562-6262 | Email: info@awaccommunityservices.org