Naria Foundation

Application Form

Please Read Before Completing the Form

Before completing the form below, please ensure that you meet the eligibility criteria for Naria Foundation services.
Due to limited capacity, eligibility is determined through a three-step process: a comprehensive review of your application, a virtual interview, and an assessment by our team of therapists.

Please note: Completion of all three steps **does *not* guarantee acceptance into the program**. If you are found ineligible, the Naria Foundation will notify you.

Important Note

Naria Foundation provides services **exclusively to individuals diagnosed with Post-Traumatic Stress Disorder (PTSD)**. Unfortunately, we are unable to offer services for other mental health conditions such as: Bipolar disorder, Anxiety, Panic attacks, Depression, Personality disorders

Eligibility Criteria for Trauma-Focused Counselling

To be considered for trauma-focused counselling, applicants must meet the following requirements:

- Be between **the ages of 16 and 24**
- Have a **formal diagnosis of PTSD**
- **Be mentally, physically, and socially stable,** meaning:
    - No acute or unstable mental/physical health conditions
    - Stable housing situation
- Not currently receiving **private or government-funded counselling services**

Naria Foundation mission is to facilitate trauma-focused counselling specifically for individuals with PTSD, ensuring that those most in need benefit from our support.

If you believe you meet the eligibility criteria outlined above, please complete the application form and attach any supporting documents, such as a psychological assessment confirming your PTSD diagnosis. Once completed, kindly email the form and attachments to Info@nariafoundation.com.

Once your application has been reviewed, we will contact you using the details provided to schedule a virtual interview.

Disclaimer

Naria Foundation facilitates and financially supports access to trauma-focused counselling. However, we are not responsible for the outcome of the counselling process itself.

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Identification:

Name :	**Family Name:**		
Preferred Name:			
Pronounced (he/she):			
Date Of Birth:			
PHN (optional):			
Phone:	**Alternative Phone:**		
E-Mail:			
Address:			
Preferred Mode of Contact	**Phone**	**E-Mail**	**Other:**
Alternative Contact: **Relationship:**	**Phone:**	**E-Mail:**	
Emergency Contact If Different From Above:			

Care Providers and Support:

- **Name of your family physician or nurse practitioner? _____**
- **Name of your psychiatrist?_____**
- **Name of your psychologist?_____**
- **Name of your counsellor or case manager and facility?**

  _____
- **Your mental health support group?_____**
- **governmental resources, facilities, or clinics that you are connected with?**

  _____

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Please provide brief details about your experience with psychosocial trauma:

- **Brief description of Traumatic Event(s)**

_____

_____

_____

- **Timeline of the Trauma**
  - Was this a single traumatic event, or has it been ongoing?
  - Specify the date or period of time it has been occurring:

_____

_____

- **Impact of the Trauma:** Briefly describe the mental and physical consequences of the trauma:

_____

_____

_____

- **Treatment History:** Have you received any treatment, such as counseling or medications?

_____

_____

_____

1. Substance Use History:

Have you had problematic use of substances (e.g., alcohol, illicit opioids, cocaine, crystal meth, GHB, ketamine, kratom, etc.) **in the last six months**? **If yes**

- **List the substances used:**

_____

- **How frequently do you use these substances?**

_____

- **When was your last use of each substance?**

_____

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- **Are you taking any medications related to substance use?**

_____

2. ***Past Medical History:*** Please let us know if you have any medical history.

_____

_____

3. ***Mental Health History:***

Have you been diagnosed with any mental health conditions?

- **If yes, what are the diagnoses?**

_____

- **What treatments have you received?**

_____

- **Provide details about any previous mental health counseling (dates, duration, and name of the counselor):**

_____

4. ***Hospitalization History:*** Have you been hospitalized in the last six months?

If yes, specify the reason and duration of hospitalization:

_____

_____

5. ***Current Medications:*** List any medications you are currently taking:

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CONSENT FOR PSYCHOLOGICAL ASSESSMENT, THERAPY, AND INFORMATION SHARING

The initial assessment session with a therapist is intended to evaluate your eligibility and readiness for PTSD-focused counselling. It also serves to clarify your concerns and explore suitable therapeutic options if you are deemed eligible. If accepted, treatment will specifically focus on strategies to address Post-Traumatic Stress Disorder (PTSD).

While therapy can offer meaningful benefits, it is important to understand that positive outcomes cannot be guaranteed. As part of the process, discussing personal or sensitive issues may evoke strong emotions, and implementing new coping strategies may lead to temporary increases in distress or anxiety.

Participation in therapy is voluntary, and you may choose to withdraw at any time.

All assessment and therapy sessions will be conducted by therapists affiliated with the Naria Foundation.

Your personal information will be treated with the utmost confidentiality. A secure electronic file will be maintained and may include your referral details, registration forms, medical history, psychological reports, and any related correspondence (e.g., emails or phone numbers).

By signing this consent form, you authorize staff at the Naria Foundation to access and manage this information. You also agree to the sharing of relevant details with professionals involved in your care, including your assigned therapist. While every effort will be made to protect your privacy, please note that full confidentiality cannot be guaranteed when using electronic communication methods such as email.

I understand that the Naria Foundation facilitates and financially supports access to trauma-focused counselling services, but is not responsible for the therapeutic outcomes or results of the counselling process itself.

ACKNOWLEDGEMENT AND CONSENT

I, _____, confirm that I have read and understood the contents of this document. I acknowledge the terms and conditions for assessment and therapy, and I voluntarily give my consent to proceed as outlined above.

Signature of Client: _____

Date: _____

Guardian/Parent (if you are under 19 years of age):

Name: _____Relationship_____

Signature:_____

Date: _____

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