**NOTE: <<delete this note on completed forms>>** Use this document to complete ATD CCMS Program Eligibility Assessments. Complete all information as applicable and as necessary to determine eligibility for programming.

If the individual is deemed eligible for programming, the completed form can be referred back to for relevant information.

\*\* *Before beginning the Eligibility Assessment Interview, the client must sign the* ***JHS CCMS Consent for Release of Information form****.*

\*\*\* *Upon enrolment, the client must also sign a* ***JHS CCMS Client Undertaking form****.*

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| **CLIENT INFORMATION** | |
| **Name:**  **Date of birth: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_  *day month year*** | **SIN:** 🞎Yes 🞎 No **Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Personal Health Number:**  **Correctional Service Number:**  **UCI Number:** |
| **Gender identity :**  🞎 Male 🞎 Female🞎 Transgender  🞎 Gender non-conforming🞎 Other:    **Height:**  **Hair Color:**  **Eye Color:**  **Weight:**  **Distinguishing marks:** | **Referring Detention Facility:**  **Referring CLO:** |
| **What country/culture/ethnicity do you identify with?** (Can be more than one)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Do you identify as Aboriginal? □** Yes □ No  **Notes:** | **Current Immigration status**  Date of arrival: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Deportation Status □ Danger Opinion Status  □ Refugee Status  □ Other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Country of origin:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Primary Language:** □ English □ French  □ Other \_\_\_\_\_\_\_\_\_\_\_ |
| **Level of Intervention** (as indicated by CBSA):  □ Low □ Medium □ High  **Level of Intervention** (as determined by JHS):  □ Low □ Medium □ High  **Notes:** | **In-person/Telephone check-ins required**  (frequency):  **Program Enrolment Date** (projected or determined): |

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| **OFFENCE AND INCARCERATION HISTORY** |
| **Did you incur any institutional charges for violent behaviour during your recent incarceration?** 🞎 Yes 🞎 No  **Details:** |
| **Did your offence attract media attention?** 🞎 Yes 🞎 No  **Details:** |
| **Is your offence related to a drug or alcohol problem?** 🞎 Yes 🞎 No **Drugs** (list)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Details:** |

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| **CURRENT INCOME STATUS** |
| 🞎 Employed 🞎 No income 🞎 Social Assistance 🞎 AISH  🞎 Employment insurance 🞎 Retired 🞎 CPP 🞎 Medical benefits |
|  |
| **WORK HISTORY**  (Note: please include number of years at each job.) |
| **JOB 1:** From YYYY-MM-DD to YYYY-MM-DD – Employer Name – Location – Job Title |
| **JOB 2:** From YYYY-MM-DD to YYYY-MM-DD – Employer Name – Location – Job Title |
| **JOB 3:** From YYYY-MM-DD to YYYY-MM-DD – Employer Name – Location – Job Title |
| **JOB 4:** From YYYY-MM-DD to YYYY-MM-DD – Employer Name – Location – Job Title |
| **CURRENT EMPLOYMENT STATUS** |
| 🞎 Full-time Employment 🞎 Part-time Employment 🞎 Unemployed 🞎 Paid Medical Leave  🞎 Student 🞎 Retired 🞎 Maternity Leave 🞎 Unable to work |

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| **CURRENT HOUSING STATUS** | | |
| 🞎 No fixed address (homeless) 🞎 Shelter 🞎 Correctional facility 🞎 Own accommodation/Rent  🞎 Hotel/Hostel 🞎 Halfway House 🞎 Treatment centre 🞎 Friend’s or Family’s dwelling  🞎 Group home 🞎 Hospital 🞎 Other: | | |
| **LEGAL STATUS** | | |
| 🞎 No previous record | 🞎 Past criminal record | 🞎 Probation |
| 🞎 Alternative Measures | 🞎 Conditional Sentence | 🞎 Day Parole |
| 🞎 Full Parole | 🞎 Statutory Release | 🞎 Upcoming Court Date |
| 🞎 Other legal disposition (s. 810, LTSO, etc.): *(please indicate)* | 🞎 Outstanding charges |  |

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| **EDUCATION** |
| **Highest grade completed in the community:** *(please circle)* 1 2 3 4 5 6 7 8 9 10 11 12  **Post-secondary**: 🞎 Some college/University 🞎 University degree/College diploma 🞎 Trades  **Indicate name of degree / accreditation / certificate :** *(all that apply)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Upgrading completed:** *(provide details if applicable)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **VEHICLE** | | | |
| **Do you own any vehicles?** 🞎 Yes 🞎 No | | | |
| **Make:** | **Model:** | **Year:** | **Licence #:** |

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| **FINANCIAL ACCOUNTABILITY** |
| **I agree to disclose financial statements and verification to staff.**  **Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** How much money do you currently have? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **POTENTIAL BONDSPERSON** |
| **Contact**: |
| **Relationship:** |
| **Address and Phone Number:** |

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| **EMERGENCY CONTACT INFORMATION** |
| **Emergency Contact**: |
| **Relationship:** |
| **Address and Phone Number:** |

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| **PHYSICIAN AND COVERAGE INFORMATION** |
| **Family Physician**: **Psychiatrist/Psychologist:**   * Yes No Yes No   **If so, who** : **If so, who** : |
| **Medical Coverage:**   * Alberta Health Care # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blue Cross \_\_\_\_\_\_\_\_\_\_\_\_\_   Treaty #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ALLERGIES** |
| **Medication Allergies:**  Yes No If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other Allergies:**  Yes No  If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **MEDICATION HISTORY** |
| **Are you currently on any prescribed medication(s)?** : Yes No  If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Were you on any prescribed medication(s) in the past?**  Yes No  If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **GENERAL HEALTH CONCERNS** | | |
| * AIDS/HIV | * Heart Disease |
| * Asthma/ Lung problems | * Hearing problems |
| * Bipolar Disorder | * High Blood Pressure |
| * Bone/Joint Pain | * High Cholesterol |
| * Cancer | * Kidney Disease |
| * Depression | * Liver Disease |
| * Diabetes Type 1 or Type 2 | * Tuberculosis |
| * Hepatitis A | * Schizophrenia |
| * Hepatitis B | * Seizures |
| * Hepatitis C | * Suicidal Ideation |
| * Hepatitis D | * Vision problems |
| * Hepatitis E | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **MENTAL ASSESSMENT** | |
| * Anxiety | * Migraines/ Headaches |
| * Confusion | * Racing Thoughts |
| * Delusions | * Rapidly Changing Mood |
| * Depressed Mood | * Trouble Concentrating |
| * Hallucinations | * Trouble Sleeping |
| * Memory Problems | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **TOBACCO/ ALCOHOL USE/MARIJUANA** |
| **Are you currently using tobacco/marijuana (**circle all that apply)**?**  Yes No  If so, for how long have you been using Tobacco/marijuana (years)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **If no, did you ever use tobacco/marijuana in the past?** Yes No  If so, for how long did you use Tobacco/marijuana ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do you struggle with alcohol abuse?** Yes No  If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **ILLEGAL DRUG USE** |
| **Have you used any illegal substances in the Institution prior to your release?**  Yes No  If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do you struggle with substance abuse?**  Yes No  If so, which ones?   |  |  | | --- | --- | | * Cocaine | * Opium | | * Crack | * Inhalants | | * Heroin | * MDMA (Ecstasy etc.) | | * Methamphetamines | * LSD | | * Amphetamines | * Prescription Pills | |  | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **HOW CAN WE HELP YOU?** | | |
| **What are your plans for the ATD program in conjunction with your release conditions?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **CLIENT’S IDENTIFIED NEEDS** | | |
| 🞎 Employment | 🞎 Addictions | 🞎 Income |
| 🞎 Education | 🞎 Mental Health | 🞎 Housing options |
| 🞎 Medical | 🞎 Anger Management | 🞎 Food Bank |
| 🞎 Understand Conditions of Release | 🞎 Spiritual | 🞎 Safety Planning |
| 🞎 Other: | | |

**ELIGIBILITY ASSESSMENT SUMMARY AND**

**PROPOSED ATD CCMS PLAN**

**Reason for Referral:**

**CBSA Identified Intervention Level (**i.e. low, medium, high**) and CBSA Proposed ATD Plan (**see referral form; indicate main service areas **– i**.e. health, mental health, employment, housing, etc. **):**

**Substance Use (**if applicable, indicate areas of concern that will require community support**) :**

**Current Medical/Mental Health Concerns:**

**Other Presenting Issues:**

**Additional Information:**

**Approved for CCMS ATD Program ? \_\_\_\_\_**

**If YES: Level of Intervention assigned by JHS (**i.e. low, medium, high**) and JHS Proposed ATD Plan (i**.e. health, mental health, employment, housing, etc. **):: \_\_\_\_\_**

**If NO: Indicate reasons denied for CCMS ATD Program:**

**Case Manager signature:**

**Case Manager name (print) :**

**Date signed:**