John Howard

PROTECTED B

ATD CCMS PROGRAM ASSESSMENT & ENROLMENT FORM

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.*

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:**

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

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	

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 #:**

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:

EMERGENCY CONTACT INFORMATION

Emergency Contact:

Relationship:

Address and Phone Number:

PHYSICIAN AND COVERAGE INFORMATION

Family Physician:

☐ Yes ☐ No

If so, who :

Psychiatrist/Psychologist:

☐ Yes ☐ No

If so, who :

Medical Coverage:

☐ Alberta Health Care # ______________

☐ Treaty #______________

☐ Blue Cross ______________

☐ Other : ______________

ALLERGIES

Medication Allergies: ☐ Yes ☐ No If so, what? ______________________

Other Allergies: ☐ Yes ☐ No

If so, what? ______________________________________

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
- ☐ Asthma/ Lung problems
- ☐ Bipolar Disorder
- ☐ Bone/Joint Pain
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes   Type 1 or Type 2
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis D
- ☐ Hepatitis E
- ☐ Heart Disease
- ☐ Hearing problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Suicidal Ideation
- ☐ Vision problems
- ☐ Other: ______________________

MENTAL ASSESSMENT

- ☐ Anxiety
- ☐ Confusion
- ☐ Delusions
- ☐ Depressed Mood
- ☐ Hallucinations
- ☐ Memory Problems
- ☐ Migraines/ Headaches
- ☐ Racing Thoughts
- ☐ Rapidly Changing Mood
- ☐ Trouble Concentrating
- ☐ Trouble Sleeping
- ☐ Other: ______________________

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? ____

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
- ☐ Crack
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Amphetamines
- ☐ Opium
- ☐ Inhalants
- ☐ MDMA (Ecstasy etc.)
- ☐ LSD
- ☐ Prescription Pills
- ☐ Other: ______________________

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ATD CCMS ELIGIBILITY ASSESSMENT & INTAKE FORM

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:		

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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:______________________________