SOUTHERN ALCARE MANOR
520 7th Street South
Lethbridge, AB T1J 2H1
403-328-0955

Southern Alcare Manor is a long-term addiction recovery program for clients aged 18+ with substance use and addiction issues.

Our facility is in the downtown core of Lethbridge with access to a wide range of services. The aim of our program is to enhance the strengths and skills of our residents on an individual basis. This design is to encourage and empower through interventions based on best practices to begin to live free of problematic substance use.

Southern Alcare Manor offers supportive opportunities to work on substance use related goals. The programs are abstinence focused and require that each resident agree to refrain from substance use while in the program.

Please note: Southern Alcare Manor is unable to accommodate those individuals that require the use of walkers, crutches, or wheelchairs.

APPLICATION PROCESS

The following suggestions may help you in the application process. Please answer all of the questions to the best of your ability.

The Southern Alcare Manor staff can provide additional information about the programs and assist with some of the client's preparation needs when required.

Once the application package is submitted by fax (403-381-2021) or email (apply.alcare@shaw.ca) clients are asked to check-in bi-weekly to maintain their status on the waitlist as changes can occur quickly.

Check-ins can be made by calling 403-328-0955, pressing option 2, and leaving a message. Your message will be recorded as part of your regular check-in. You can also send an email to apply.alcare@shaw.ca

If you have been diagnosed with any physical or mental health concerns please provide information such as:

- your doctor's name and current contact information, and
- an up-to-date list of your medications.

If you are coming to us from another program please provide us with your discharge summary from that program.

Please ensure that the following documents are reviewed and signed before submitting them, this will help speed up the process from our end.

- Consent to Release / Obtain Confidential Information
- Applicant Informed Consent for Services
- Participant Agreement
- Early Exit Transition Plan

INFORMATION FOR REFERRING AGENCIES

It is very important that the client fill out as much of this application as possible . This helps staff with assessing the individual needs.

As a referring service provider, you play an important role in helping your client succeed as follows:

- supporting client preparation, admission, engagement, retention, and therapeutic alliance,
- maintain community support with a client and his / her care team,
- help the client maintain a connection to the community, and
- support transition planning and timely return to the community.

If you are not able to stay involved with the client you are referring please help your client get connected to a resource that **can** provide this support. If this is **not possible**, please alert our recovery team so they can help connect the client to resources in the community.

TRANSITION PLANNING

Transition planning starts as early as possible in the resident's stay at Southern Alcare Manor.

The resident and staff will work together as early as possible to develop a transition plan.

If a resident has been made aware of an issue that may result in early discharge from the program, staff will strive to facilitate a safe transition for the resident.

An Early Exit Transition Plan is vital to maintaining a resident's safety, **especially in** situations where a resident is discharged from the program early with little notice or if the resident decides to leave the facility early.

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REFERRING AGENCY INFORMATION		
Date of Referral:	Office Use Only	
Who is making the referral?		
Name:		
Agency:		
Role:		
Phone:	Email:	Fax:
How many sessions have you had with the client?		
Will you continue to support your client through and after treatment at Southern Alcare Manor? **Yes or No**		

APPLICANT INFORMATION		
Legal Name:	Preferred Name(s):	
Birthdate: Age:	Marital Status:	
Health Care Number:	Preferred Pronouns:	
Street Address:		
City:	Province:	Postal Code:
Your Telephone Number	Your Contact's Phone Number	Would it be okay to leave a message at this number for you? Yes or No
Email:		
Emergency Contact Information:		
Name:	Relationship:	Phone:
Can we contact this person if you are discharged early from Southern Alcare Manor? **Yes or No**		
If no, is there another individual we can contact in this situation? **Yes or No**		
If yes, please provide name:	Phone:	
Do you have any children under 19 years of age? **Yes or No**		
If yes, are they currently living with you? **Yes or No**		
Is Child Welfare involved: **Yes or No**		
Please provide additional information if necessary:		

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CULTURAL INFORMATION	
Applicant Name:	**Referral Date:**
We invite you to let us know if there are any traditional practices or ceremonies that will support your wellness while at Southern Alcare Manor:	
Is there anything you would like is to know about you or your culture that we have not included here?	
Do you identify yourself as an Aboriginal person, First Nations, Metis or Inuit? **Yes or No**	
If you identify as an Aboriginal person, are you: First Nations Metis Inuit	
Status: **Yes or No**	Band:
APPLICANT'S STRENGTHS, INTERESTS, AND HOPES	
Tell us about your strengths and positive qualities:	
Please write a short paragraph describing your treatment plan.	

TREATMENT HISTORY CONTINUED	
Applicant Name:	**Referral Date:**
Have you completed a withdrawal management program such as Detox? **Yes or No**	
If yes, please list the most recent dates, where, and for what substances:_____ Do you have a history of seizures or DT? **Yes or No**_____ What is your clean date?_____	
Have you ever participated in substance use services and supports? (Including counselor, outpatient clinic, AA, NA, etc.)? **Yes or No**	
If yes, please list the most recent dates, where, and for what substances:	
What has been helpful in your past recovery or support experiences?	
What has <u>not</u> been helpful in your past treatment or support experiences?	

GENDER AND SEXUAL ORIENTATION		
Male	Female	Gender Creative / Fluid
Transgender: **MTF FTM**	Other:	Prefer not to answer
What pronoun would you like us to use? **He She They** Other:		
Sexual orientation is diverse, we invite you to let us know your sexual orientation:		

Heterosexual	Lesbian	Gay	Bisexual
Queer	Questioning	Two-Spirit	Pansexual
Asexual	Other:	Prefer not to answer	

Is your reason for getting help (substance use, mental health concerns) related to issues around your sexual orientation or gender identity?		
Not at all	A little	Somewhat
A lot	Unsure	Prefer not to answer

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SUBSTANCE USE

Applicants Name: **Referral Date:**

Primary Problem	Substance	What Was Your Method of Use?	Amount Used in a Typical Day	How old were you when	Date of Last Use
	Alcohol				
	Non-Beverage Alcohol				
	Bath Salts				
	Cannabis				
	Crack Cocaine				
	Cocaine				
	Heroin				
	Carfentanyl				
	Fentanyl				
	Oxycontin				
	Morphine/ Hydromorphone				
	Demerol				
	Benzothiazine				
	Hydrocodone				
	Crystal Meth				
	Amphetamines				
	GHB				
	Ecstasy / MDMA				
	Ketamine				
	Inhalants				
	Over the Counter				
	Prescription Drugs				

Have you ever overdosed? **Yes** **or** **No**
When was your most recent overdose? _____
If yes, how many times have you experienced an overdose? _____

DIETARY REQUIREMENTS		
Applicant Name:	**Referral Date:**	
Do you have any special dietary needs? **Yes or No**		
If yes, please describe:		
Do you have any food allergies? **Yes or No**		
If yes, please list:		
Do you have any dietary sensitivities? **Yes or No**		
If yes, please explain:		
Do you have any history of disordered eating? **Yes or No**		
If yes, please explain:		
Have you ever had a problem with any of the following?		
Binging **Yes or No**	Purging **Yes or No**	Abuse of Laxatives **Yes or No**
Have you ever had a problem with excessive exercising?		
If yes, please explain:		
Have you ever participated in treatment for disordered eating? **Yes or No**		
If yes, please explain:		
MOBILITY CONCERNS		
Do you have any mobility issues? **Yes or No**		
Do you have problems with managing stairs? **Yes or No**		
Do you have problems sitting for an hour? **Yes or No**		
Do you have back problems? **Yes or No**		
Do you require frequent rest periods during the day? **Yes or No**		

MENTAL HEALTH				
Applicant Name:		**Referral Date:**		
Have you ever experienced any periods of psychosis or hallucinations? Yes or No If yes explain? When this happened and was it drug related?				
When was the last time you had significant problems with?				
When was the last time you had sign				
1. Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?				
Past Month	2 – 3 mon ago	4 – 12 mon ago	1+ year ago	Never
2. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?				
Past Month	2 – 3 mon ago	4 – 12 mon ago	1+ year ago	Never
3. Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?				
Past Month	2 – 3 mon ago	4 – 12 mon ago	1+ year ago	Never
4. Becoming very distressed and upset when something reminded you of the past?				
Past Month	2 – 3 mon ago	4 – 12 mon ago	1+ year ago	Never
5. Seeing or hearing things that no one else could see or hear, or feeling that someone else read or control your thoughts?				
Past Month	2 – 3 mon ago	4 – 12 mon ago	1+ year ago	Never
CURRENT MEDICATIONS				
Please provide a list of medications that have been prescribed to you. You may be able to obtain this list from your Doctor or Pharmacist.				
Do you have any concerns about your current medications? Yes or No Please explain your concerns.				
Do you have any drug allergies? **Yes or No**				
Are you on current Opiate Maintenance Therapy? Yes or No What type of therapy are on? Who prescribes your medication?				
Start Date:		Current Dose:		

PSYCHOLOGICAL AND SOCIAL	
Applicant Name:	**Referral Date:**
Are you currently in an abusive environment? **Yes or No**	
Are you fleeing an abusive relationship? **Yes or No**	
If yes, please explain:	
Have you ever experienced or witnessed violence in the past? **Yes or No** **(Such as abuse, neglect, sexual assault, or forcible confinement?)**	
Have you been treated for PTSD or Trauma	
If yes, to any of the above questions please briefly describe the areas of concern.	
Do you have concerns for your safety related to your care while in the program? **Yes or No**	
If yes, please explain?	
Do you have any concerns about being in a group setting / environment? **Yes or No**	
If yes, please explain:	
Do you have any concerns regarding your safety after you leave this program **Yes or No**	
If yes, please explain:	

LEGAL INFORMATION		
Applicant Name:	**Referral Date:**	
Are you on probation or parole? **Yes or No**		
Do you have a conditional sentence? **Yes or No**		
If **yes** to either of the above, *please provide contact information for parole or probation on the consent form.*		
Are you currently under any of the following orders?		
Probation: **Yes or No**	Bail: **Yes or No**	Parole: **Yes or No**
Do you have any current legal restrictions? **Yes or No**		
Please Note: **We ask that you provide us with all court conditions or fine related information prior to admission.**		
Have you ever been charged or convicted of the following?		
Trafficking: **Yes or No**	If yes, when?	
Theft: **Yes or No**	If yes, when?	
Parole Violations: **Yes or No**	If yes, when?	
Drug Charges: **Yes or No**	If yes, when?	
Weapons Offences: **Yes or No**	If yes, when?	
Sexual Assault: **Yes or No**	If yes, when?	
Robbery: **Yes or No**	If yes, when?	
Assault: **Yes or No**	If yes, when?	
Arson: **Yes or No**	If yes, when?	
Manslaughter / Murder: **Yes or No**	If yes, when?	
Family Violence: **Yes or No**	If yes, when?	
Impaired: **Yes or No**	If yes, when?	
Willful Damage: **Yes or No**	If yes, when?	
Break and Enter: **Yes or No**	If yes, when?	
Forcible Confinement / Kidnapping: **Yes or No**	If yes, when?	
Intimate Partner Violence: **Yes or No**	If yes, when?	
Gang Affiliation: **Yes or No**	Active: **Yes or No**	
If you are no longer active in gang affiliation explain how you were able to separate:		

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CONSENT TO RELEASE / OBTAIN CONFIDENTIAL INFORMATION	
Applicant Name:	**Referral Date:**
I _____ (full name), born _____ (date) do hereby consent and authorize my Recovery Coach _____ (name) Designates name _____ Therapist's name _____ to release any information pertaining to me to the agencies / persons indicated below, and I also authorize the indicated sources to release information / documentation regarding my case to _____ (name):	
○ Department of Children and Families Services Contact Person and Phone Number:	
○ Alberta Works (location): Contact Person and Phone Number:	
○ Attorney Name and Phone Number:	
○ Alberta Addictions and Mental Health Services Counselor Name and Phone Number:	
○ Psychiatrist / Psychologist Name and Phone Number:	
○ Physician or Pharmacist Contact Name(s) and Phone Number(s):	
○ Probation Officer Name and Phone Number:	
○ Parole Officer Name and Phone Number	
○ Family Member(s) Name(s) and Phone Number(s):	
○ Other Name and Phone Number:	

CONSENT TO RELEASE / OBTAIN CONFIDENTIAL INFORMATION CONTINUED	
Applicant Name:	**Referral Date:**
Listing of specific information which may be disclosed in special cases: (check all that apply):	
○ Pharmacist's Name:	
○ Location	
What information can be released?	
○ Therapy	
○ Dose	
○ Duration	
○ Netcare drug level results	
○ Discussions regarding changes in medication time and dosage	
○ Psychiatric Assessment	
○ Information necessary for the processing and payment of program billing	
○ Other	
A listing of why this information is needed – e.g. for the following purposes: (Check all that apply)	
○ Provide ongoing treatment / continuing care	
○ Obtain insurance / employment / government benefits	
○ Coordinate services with authorized agencies	
○ Coordinate program intervention efforts with my family / significant other / concerned person	

The duration of this authorization is until: ○ Six months from the date of my case's discharge from the program ○ Resolution of billing for program services ○ Other:
I understand that I may revoke this consent at any time by notifying the facility in writing, except to the extent that information has already been released to the identified party. A photocopy of this authorization is to be considered as valid as the original document.

Applicant Signature:	Date:
Witness Signature:	Date:

INFORMED CONSENT FOR SERVICES

Purpose: For you to understand the process and nature of our treatment program as well as the associated risks and benefits, so you can make an informed decision about whether or not to participate.

Moving into a residential treatment center is not an easy transition for anyone seeking to recover from addiction. Engaging in recovery services takes a lot of courage and provides you with the opportunity to discover much about yourself and your behaviors. This may be your first experience and it is important for you to understand what treatment is about. Please read through the attached materials carefully and bring up any questions that you have so that we can discuss them. We will ask that you sign this consent form once we have discussed it so that we will have in our records that you have read and had the opportunity to discuss the information with Southern Alcare Manor (SAM) staff.

SAM Philosophy and Services

Southern Alcare Manor is a 3rd Stage model of treatment and is based upon abstinence from using addictive substances and materials. Our program is designed to consist of mandatory attendance at group sessions during the daytime and some evenings, continued support in transitioning back into society through obtaining/returning to work or education and finding suitable housing and services to aid daily living.

While a resident of SAM you will be assigned a Recovery Coach. This staff member will be available to help you in navigating your way through the maze of services available in the community. Your Recovery Coach will help you determine your recovery plan and lead your progress reviews to keep you focused on your goals and lifestyle commitments.

You will also be assigned a therapist who will assist you with any mental health concerns and provide professional help in accomplishing any desired changes you would like to make in your life. Your wishes and goals will be considered because the philosophy of SAM also includes the concept of “meeting you where you are at” and helping you get to where you would like to be as you exchange old patterns for new ones. Our staff communicate to other services available including, but not limited to psychiatrists, medical providers, pharmacies, therapy specialists, etc. We work hard to ensure you become connected with any needed services.

Treatment Risks and Benefits

Recovery Treatment is different than just going to a self-help meeting. Our services have specific goals, set largely by you, and though our services may be supportive they will also challenge you. Sometimes you might feel annoyed, tired or upset following a

group session, or having to participate in house chores. This can happen as you incorporate new ways of living and thinking and filling blocks of time formerly filled by substance-seeking behaviors. You will also be living in a communal setting with other adults as roommates, or dinner mates in the dining room, or sharing a television in the evening with others who don't have your same tastes and preferences. As you progress through your time in our program and accumulate clean days you will experience changes in your beliefs and activities or relationships that may have unexpected results. Usually, these changes are very positive in the long-term, but it may be difficult to experience them as they are occurring.

You may be exposed to specific psycho-educational groups and ideas that are new to you. If you have any questions about these things it is important that you ask them. It is also important for you to know that you have the right to terminate your participation in our program at any time. Our program is safe, with doors that lock and prevent the outside influences from getting in. These doors are not locked to keep you in. You may leave the program at any time and attend alternative programs or attempt to recover on your own. There are similar programs in Medicine Hat, Calgary, Red Deer, Edmonton, and in other communities throughout the province. There is also a Detoxification Centre in the Chinook Regional Hospital, one in Fort McLeod, a 2nd Stage recovery center east of Lethbridge, and a supervised consumption site in the city. There are also various services in Lethbridge that offer services you may access on your own. Feel free to ask for referral information.

Program Costs

The only things one needs to pay for individually include toiletries, tobacco, towels, and outside entertainment. We prefer that personal belongings be kept to a minimum. A good quality pillow may also be useful if one has preferences.

Conflict of Interests

SAM staff have limits on the types of interactions they may have with residents; professional boundaries must be maintained. Staff will not pursue relationships with residents other than those required in the provision of services. Staff will not give legal, medical, financial or other professional advice. Staff will not have romantic, friendship, or sexual relations with clients. Staff will neither give nor accept gifts from residents. Staff will not attend personal parties or other events sponsored by residents or their families and friends.

It is important for residents to feel safe while at SAM. If there is a perceived conflict with staff, or the assigned Recovery Coach or therapist, you have a right to request a change, or even a referral to another agency.

It is also important for staff to feel safe in their work, and their concerns will be considered if they should begin to feel uncomfortable in caring for you.

This can occur if their personal values, experiences, or reactions interfere with their ability to provide you with the best care possible.

It is very important that everyone realize this is a residential program, where adults from disparate backgrounds live and work. Procedures will be enacted to ensure the safety of all involved. Incompatibilities will be dealt with in the least restrictive way possible.

APPLICANT INFORMED CONSENT FOR SERVICES	
• I have read the Informed Consent for Services document, had enough time to consider it carefully, asked any questions that I need to, and understand it.	
• I understand that I will be assessed for progress at intervals.	
• I understand the SAM philosophy of working with me where I am.	
• I understand the SAM philosophy of abstinence.	
• I understand the benefits and risks of participating in this program.	
• I understand that my behaviors must be compatible to the program and cooperative in nature.	
• I understand that any conflicts with Staff or other residents will be investigated and dealt with in the least restrictive way.	
• I understand that there are alternate services available to me.	
• I understand that I may be referred to appropriate services.	
• I agree to participate in the recovery program offered at Southern Alcare Manor.	
Applicant Name:	Signature:
	Date:
I, _____, have discussed the issues within this consent with the above applicant. My observations of this person's behavior and responses indicate that this person understands the philosophy and provisions of the treatment offered as set out above and is competent to give informed and willing consent.	
Staff Name:	Signature:
	Date:

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PARTICIPANT AGREEMENT

I _____ (full name) agree that while I am in the program at Southern Alcare Manor I understand:

- I will treat others with respect and dignity without discrimination.
- I will honor the privacy and right to confidentiality of others.
- that if I relapse I will be suspended immediately. My time to appeal this decision is within 3 business days.
- That if I am suspected of substance abuse, gambling or participating in any criminal activity. I have the right to appeal this decision within 3 business days.
- I may be suspended following a review of the situation.
- That I will give full disclosure of all criminal charges or court ordered conditions or any gang affiliation prior to being accepted at Southern Alcare Manor.

I agree to participate in the following activities upon arrival at Southern Alcare Manor:

- medication review including handing in all medications to the program staff,
- urine sample and breathalyzer if requested,
- review of your personal belongings in your presence,
- program orientation with staff.

Applicant Name:	Signature:
	Date:
Witness	Witness's Signature:
	Date:

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EARLY EXIT TRANSITION PLAN	
Return to my home and / or the home of the individual named below for immediate shelter and transition support and / or contact the agency / worker named below for immediate shelter and transition support.	
Early Exit Contacts:	
1. Name:	Relationship:
Home Phone:	Cell:
2. Name:	Relationship:
Home Phone:	Cell Phone:
3. Organization / Agency Name:	Contact / Worker Name:
Phone:	Cell:
Applicant Name:	Signature:
Witness's signature	Date:
Additional Information (e.g. Details of your Early Exit Transition Plan)	

Office Hours are Monday to Friday 8:00 am – 5:00 pm
For general enquiries please email or call using the contact information below.
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Fax: 403-381-2021
Email: apply.alcare@shaw.ca