

WOODLAND WELLNESS CENTRE

PARTICIPANT INTAKE PACKAGE

Woodland Wellness Centre
Box 850, Air Ronge, SK. S0J 3G0
PH: 306-425-1930 Fax: 306-425-1920

DATE: _____

PARTICIPANT NAME: _____

PARTICIPANT INFORMATION:

Last Name: _____ First Name(s) _____ D.O.B. _____

Nickname: _____ Self-Identified Gender: Male Female Other

Status Indian: Yes No First Nation/Band: _____ Live On-Reserve: Yes No

Band Number: _____ Treaty Number: _____

Health Insurance Number: _____ Social Insurance Number: _____

Address [home]: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Marital Status: Single Married Common-Law Widowed Divorced Separated

Family Type: Living Alone With Partner With Partner & Children With Friends

Single Parent with Children With Extended Family

Number of children & ages: _____ Child & Family Services involved: Yes No

Are you mandated to treatment by court or child family services: Yes No

Do your children live with you: Yes No. If yes, how many? _____

Education Level: Grade Completed _____ High School Diploma Trade School Post-Secondary

Difficulty Reading & Writing: Yes No Learning Difficulties: Yes No

Employment: Full-Time Job Part-Time Job Unemployed Seasonal Work Home Maker

Student Residential School Attendance: Yes No. If yes, how long? _____

Did you have a family member attend residential school? Yes No If yes, please explain: _____

Do you require a wheelchair accessible room: Yes No If yes, please explain: _____

Do you have any physical limitations WWC needs to be aware of: Yes No

Please explain: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cellphone: _____

PARTICIPANT DOES NOT WISH TO HAVE CONTACT WITH THIS/THESE PERSON (S): _____

SUBSTANCE USE/PROCESS ADDICTION - HISTORY

SUBSTANCE OF ABUSE	METHOD OF USE: ORAL/SMOKED/SNORTED/IV	LENGTH OF USE	AMOUNT CONSUMED DAILY	DATE OF LAST USE

TYPE OF GAMBLING OR OTHER PROCESS ADDICTION (FOOD DISORDER, INTERNET, SEX, ETC)	DURATION OF PROBLEM GAMBLING OR OTHER PROCESS ADDICTION	FREQUENCY OF GAMBLING OR OTHER PROCESS ADDICTION	LAST DATE OF GAMBLING OR OTHER PROCESS ADDICTION	SOGS (SOUTH OAKS GAMBLING SCORE) OR OTHER SCREENING TOOL

Do you smoke cigarettes? Yes No If yes, how many cigarettes/day? _____

Please attach any assessments, including summaries completed in the last 7 weeks (SASSI, MAST, Etc.) which supports application to inpatient treatment admissions.

Check off areas negatively impacted by your use:

<input type="checkbox"/>	Housing	<input type="checkbox"/>	Relationships	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Employment	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	School	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Legal	<input type="checkbox"/>	Financial	<input type="checkbox"/>	Leisure time	<input type="checkbox"/>	Other:

Family history of substance addiction? Yes No

If yes, please explain: _____

TREATMENT HISTORY:

Have you previously attended Inpatient Treatment? Yes No

Year: _____ Treatment Centre _____, Type of addiction _____, Completed: _____.

Year: _____ Treatment Centre _____, Type of addiction _____, Completed: _____.

Year: _____ Treatment Centre _____, Type of addiction _____, Completed: _____.

Have you ever been discharged, or Self discharged from treatment? Yes No

If yes, please explain: _____

Longest period being substance free? _____.

What helped to stay substance free previously? _____

Reason for requesting treatment currently? _____

Have you ever attended: Wellbriety Meetings A.A. N.A.
 Support groups Other _____.

What are your strengths and motivation for Inpatient treatment? _____

What will prevent you from successfully completing Inpatient treatment? _____

Do you have any dependent children under your care? Yes No

If yes, share your plan for childcare while in treatment: _____

What are your expectations and goals from Inpatient Treatment: _____

LEGAL:

Have you ever been convicted of a crime? Yes No

If yes, please explain: _____

At the time of the offence were you under the influence of any substances? Yes No N/A

If yes, please explain: _____

Do you have any charges currently pending? Yes No

If yes, what are your charges? _____

Do you have an up-coming court date: _____

Current legal status: _____

Gang involvement? if so, please explain: _____

Important Note for Admission

- **Attach legal papers with treatment application. (Probation orders, CSO, Etc.).**
- **Applicant must have all legal affairs in order before being admitted into treatment. Meaning no upcoming court dates while in treatment, Inpatient Treatment requires 100 percent participation in healing sessions by the client.**
- **Woodland Wellness Centre does not accept charged or convicted sex offenders.**

MEDICAL HISTORY:

History of seizures, heart condition, diabetes or other? Yes No N/A

If yes, please explain: _____

Ever been hospitalized/ detoxed for excessive substance use? Yes No

If yes, please explain: _____

Participant currently Pregnant? Yes No N/A

Due Date _____

Any family psychiatric history: _____

Do you have any psychiatric illnesses or symptoms? _____

Any other medical issues WWC should be aware of? _____

Do you have any allergies? _____

Do you use an Epi-pen?: _____

Do you have any dietary requirements? _____

REFERRAL AGENT:

Name: _____ Community: _____

Title: _____ Phone: _____

Email: _____

What are your clinical/ holistic interpretations of your participant _____

Where is your participant on the "Stages of Change" **Check one**

- Pre-Contemplation Contemplation Preparation Action Maintenance

Describe important areas that need to be addressed during your participant's treatment stay? _____

Once participant has completed treatment, please provide a Treatment plan and timeline of ongoing after care _____

Post-Treatment appointment date for participant with referral agent: Click or tap to enter a date.

REFERRAL ASSESSMENT

Has the participant ever been professionally assessed by a psychologist or psychiatrist? Yes No

If yes, please provide dates and details. **Attach a copy of the assessment:** _____

Check all applicable boxes:

- TRAUMA DEPRESSION ANXIETY/PANIC DISORDER ANY TYPE OF MENTAL HEALTH DISORDER
ANGER/ACTING OUT FAMILY TRAUMA (child apprehension, custody problems, lateral violence, marriage breakdown, etc.)
GRIEF AND LOSS FAS/FAE SUICIDE IDEATION SUICIDE ATTEMPTS

Please provide brief explanation: _____

Is suicide a concern? Yes No If yes, what is the level of risk? _____

***NOTE* Please attach a copy of suicide risk assessment and safety plan, if in the last 12 months.**

PARTICIPANT SNAP (Strength, Needs, Abilities, Preferences) (To be answered from the participant's perspective).

What does the participant believe as their:

Strengths (assets, resources): _____

Needs (liabilities, weaknesses): _____

Abilities (skills, aptitudes, capabilities, talents, competencies): _____

Preferences (those things the participant thinks, feels will enhance HIS/HER treatment experience): _____

In the participants own words, what are their presenting problems and challenges? _____

PARTICIPANT SCREENING:

ALCOHOL SCREENING TEST	
The following questions are about your alcohol use during the PAST 12 MONTHS (Check your response).	
Do you feel that you are a normal drinker? <input type="checkbox"/> Yes (0) <input type="checkbox"/> NO (2)	Do friends or relatives think you are a normal drinker? <input type="checkbox"/> Yes (0) <input type="checkbox"/> No (2)
Have you attended a meeting of A.A.? <input type="checkbox"/> Yes (5) <input type="checkbox"/> No (0)	Have you lost friends or girlfriends/boyfriends because of your drinking? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
Have you gotten into trouble at work because of your drinking? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)	have you neglected your obligations, your family, or your work for two or more days in a row because you were drinking? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
have you had delirium tremens (DT's), severe shaking, heard voices or seen things that were not there after heavy drinking? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)	have you gone to anyone for help about your drinking? <input type="checkbox"/> Yes (5) <input type="checkbox"/> No (0)
have you been in the hospital because of drinking? <input type="checkbox"/> Yes (5) <input type="checkbox"/> No (0)	have you received a 24-hour roadside suspension, or have you been charged for impaired driving? <input type="checkbox"/> Yes (2) <input type="checkbox"/> No (0)
Total scores may range from 0 to 29 (scores of six are greater are considered to reflect serious problems with alcohol).	TOTAL SCORE:

DRUG SCREENING TEST	
The following questions are about your alcohol use during the past 12 months (please check your response).	
have you used drugs other than those required for medical reasons? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you abused prescription drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
do you abuse more than one drug at a time? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	can you get through the week without using drugs? <input type="checkbox"/> Yes (0) <input type="checkbox"/> No (1)
are you always able to stop using drugs when you want to? <input type="checkbox"/> Yes (0) <input type="checkbox"/> No (1)	have you had blackouts or flashbacks as a result of drug use? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
do you ever feel bad or guilty about your drug use? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	Does your spouse or parents ever complain about your involvement with drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
has drug abuse created problems between you and your spouse or your parents? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you lost friends because of your use of drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
have you neglected your family because of your use of drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you been in trouble at work because of drug abuse? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
have you lost a job because of drug use? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you gotten into fights when under the influence of drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
have you engaged in illegal activities in order to obtain drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you been arrested for possession of illegal drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you had medical problems as a result of your drug use (I.E. Memory loss, hepatitis, convulsions, bleeding) ? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
have you gone to anyone for help for drug problems? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	have you been involved in a treatment program specifically related to drug use? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Score: 0 No Problem 1-5 Low 6-10 Moderate 11-15 Substantial level 16-20 Severe	Total score:

REVIEW THE FOLLOWING WITH PARTICIPANT. PARTICIPANT MUST CHECK EACH BOX AND SIGN BELOW.

I understand in order to be admitted to WWC Residential Treatment, I must remain alcohol and drug free for at least 7 full days prior to my admission/intake date and be well enough to participate in the healing sessions. If I arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, I will be asked to leave the WWC and will be required to reapply for treatment.

I understand that the WWC is not responsible for my transportation or any other personal costs I may incur (I.E., cigarettes, snacks, etc.) while I am in treatment.

I will bring all medications I am taking; I understand the medications might be bubble packed and kept in a secure area. I understand all unsafe or unapproved medications will be properly disposed of on treatment intake day (see page 16 of 16 for the unsafe medications).

I understand I cannot schedule any personal appointments (I.E.: hair appts., court, non-emergent dr. appts., etc.) for the period while in treatment as I must focus on my treatment healing sessions.

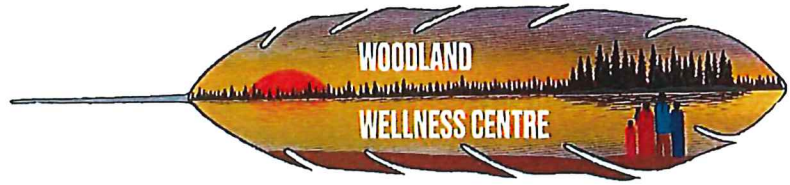
I understand and agree to accept and attend all components of the treatment healing sessions as suggested by the WWC staff - including all land-based activities, one on one counselling sessions and group Healing Sessions.

Participant signature:

Date:

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PH: 306-425-1930 Fax: 306-425-1920



I, _____, hereby release
The Woodland Wellness Centre from any legal liability in the case of an
accident/injury while attending the sweat-lodge, meat/medicine preparation,
special events, any self-help meetings, use of equipment, use of fitness facility at
JRMCC, or any other indoor/outdoor activities that occur off the premises of the
Woodland Wellness Centre.

Dated in the Province of Saskatchewan, _____

Participant Signature

Staff Signature (Witness)

Referral Agent Signature

Woodland Wellness Centre

Confidentiality Protocol

You are entitled to enter the Woodland Wellness Centre with the understanding that any information disclosed to a staff member will be held in strict confidence. This is inclusive of all records, materials, oral or written communication.

Counsellors may choose or be obligated to break confidentiality under the following circumstances:

1. You disclose that you are intending to harm another person.
2. You admit to a plan to harm yourself.
3. You disclose that a child less than 16 years of age is being abused or neglected.
4. You are in medical distress and unable to speak.
5. Your file is subpoenaed by the court.
6. The police have a warrant for your arrest.

Staff members of the Woodland Wellness Centre are bound by the rule of non-disclosure during and after employment at the Woodland Wellness Centre.

As well, you can not share any information about another participant or share if another participant is in treatment. A simple definition of confidentiality is: **“Who you see here, what is said here, when you leave here, let it stay here”**.

Date: _____

Participant Signature

WWC Counsellor Signature

Referral Agent Signature

PLEASE NOTE, ALTHOUGH ALL PARTICIPANTS SIGN A CONFIDENTIALITY PROTOCOL FORM WHILE ATTENDING AT THE WOODLAND WELLNESS CENTRE, THIS DOES NOT MEAN THAT THEY WILL MAINTAIN CONFIDENTIALITY.

Medical Form (Must be completed by Physician or Nurse Practitioner)

Participant First Name: _____ Last Name: _____

Participants Date of Birth: _____ Health Card Number: _____

Physician Name: _____ Phone Number: _____

Please check yes or no to indicate if client is currently being treated for or if they have a history of any of the following:

	YES	NO	PLEASE PROVIDE DATES AND DETAILS
Tuberculosis	<input type="radio"/>	<input type="radio"/>	
Heart Disease	<input type="radio"/>	<input type="radio"/>	
Mental Illness	<input type="radio"/>	<input type="radio"/>	
Epilepsy	<input type="radio"/>	<input type="radio"/>	
Seizures – other than Epilepsy	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	
Allergy	<input type="radio"/>	<input type="radio"/>	
Stroke	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	
Back Pain	<input type="radio"/>	<input type="radio"/>	
Venereal Disease	<input type="radio"/>	<input type="radio"/>	
Emphysema or other Lung Disease	<input type="radio"/>	<input type="radio"/>	
HIV/AIDS	<input type="radio"/>	<input type="radio"/>	
Hepatitis A B C	<input type="radio"/>	<input type="radio"/>	
Scabies	<input type="radio"/>	<input type="radio"/>	
Lice	<input type="radio"/>	<input type="radio"/>	
Pregnancy	<input type="radio"/>	<input type="radio"/>	LPM / / / Live Births: D M Y
Special Diet	<input type="radio"/>	<input type="radio"/>	
CURRENT MEDICATIONS	DOSAGE	REASONS/COMMENTS	
_____	_____ _____ _____	_____	
_____		_____	
_____		_____	

IMPORTANT NOTE FOR AMDMISSION CRITERIA

- The participant's 1 WEEK SUPPLY of medications are required to be blister packed
- Please list admission diagnosis with a brief history of present active medical conditions.
- Provisions for any follow-up treatments or care required while in WWC? Please specify.
- Any pertinent physical exam findings? Please specify.

Medical Form Continued

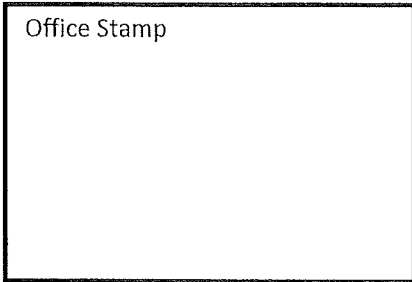
Physician/Nurse Practitioner Name: _____

Address: _____

Phone: _____ Fax: _____

Physician/Nurse Practitioner Signature

Date



NOTE: Please ensure you have read and reviewed the Safe/Unsafe Medication List on page 16. Non-compliance with said list will result in the applicant not being accepted into Woodland Wellness Centre.

Woodland Wellness Centre Fax #: 306-425-1920

UNSAFE

Avoid pain medications that contain Opiates (I.E. Codeine):

- Tylenol 1, 2, 3 or 4 (all Opioids)
- Demerol
- Percocet
- Fiorinal Plan ¼ or ½
- Levo-Dromoran
- 222, 282, 292, 692, Darvon (Propoxyphene)
- Talwin
- Percodan
- Leritine
- Dilaudid
- Nabilone
- Gabapentin

Avoid Nerve and Sleeping Pills including:

- Librium
- Tranxene
- Serax
- Xanax
- Others used for anxiety/nervousness/ tranquilizer
- All Benzodiazepines

Avoid CNS Stimulants such as Methamphetamines:

- Dextroamphetamine (Dexedrine)
- Lisdexamphetamine

Avoid Sleeping Pills including these and others:

- Dalmane
- Halcion
- Restoril
- Tuinal
- Seconal
- Zopiclone (Imovane)

Avoid Muscle Relaxants:

- Robaxisal
- Robaxacet
- Parafon
- Flexeril

Over the Counter Medications can be a Serious Threat:

- Cough syrups contain alcohol, codeine and antihistamines. These are all drugs which need to be avoided.

Avoid Sedating Antihistamines such as:

- Gravol
- Actifed
- Dimetap
- Chlortriplon
- Benydril or products containing diphenhydramine

SAFE

Pain Medications:

- ASA or Aspirin
- Advil or Ibuprofen
- Midol

Available Only by Prescription:

- Tryptan
- Buspirone (Buspar)
- Toradol
- Possible other prescription medications – please contact Resident Nurse for clarification

Antidepressants Safe with Proper Use and by Prescription Only:

- Elavil
- Citalopram
- Morex
- Serzone
- Desipramine
- Effexor (Venlafaxine)
- Zoloft (Sertraline)
- Prozac (Fluoxetine)
- Luvox (Fluvoxamine)
- Paxil (Paroxetine)
- Trazodone (Desyrel)
- Mirtazapine
- Bupropion
- Seroquel (Quetiapine)

Migraines:

- Imitrex

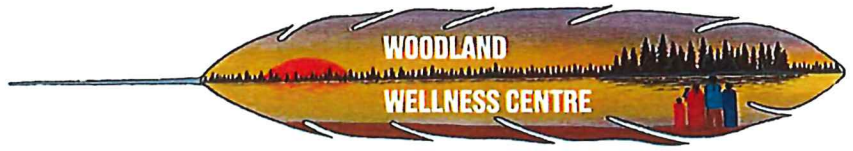
Non-Sedating Antihistamines:

- Seldane
- Claritin
- Hismanil

Sleep Aids:

- Epsom Salt
- Melatonin
- Calcium (333mg) Magnesium (167mg) with VD3 (5mcg)
- Lavender Oil

Note: This is a partial list. If you require more information, please ask the doctor or pharmacist about non-psycho active/mood-altering medications.



Woodland wellness centre

Participant name:

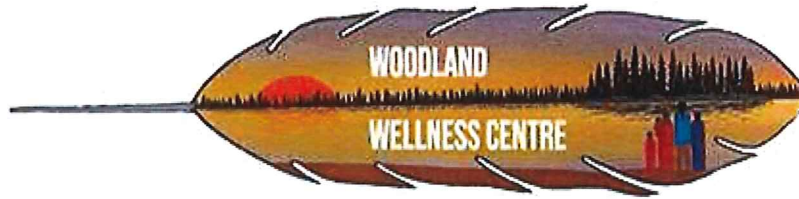
Allergies:

Age:

Date	Time	Drug name, Dose, Route, Dosing interval. One week supply.	MAR	Nurse initials
		Thiamine 100mg PO daily (for 7 days)		
		Folic Acid 1mg PO daily (for 7 days)		
		General medications: Take medications as previously prescribed in bubble pack.		
		Ibuprofen 200 mg 1-2 tabs every 6-8 hours by mouth when needed.		
		Tylenol 500 mg 1-2 tabs every 4-6 hours by mouth when needed.		
		Dimenhydrinate (GRAVOL) 25-50mg every 6 hours by mouth when needed.		
		DiphenhydrAMINE (Benadryl) 25-50mg every 6 hours by mouth and reassess participant within 30 minutes. If symptoms persist or progress and signs of severe allergy/anaphylaxis, transport to Emergency department and consult physician directly.		
		NIX Shampoo 1%- apply once and repeat in 7 days, if lice or nits still present.		

Prescriber signature:

Date/time:



Woodland Wellness Centre

Treatment House Guidelines

The Woodland Wellness Treatment Centre offers addictions treatment services to people with alcohol, drug and gambling problems. During your stay, we will work with you to help you address these problems and we kindly ask you to follow the WWC Addictions Treatment Plan. To help with this, please follow the House Guidelines listed:

1. At no time will participant(s) threaten or try to intimidate WWC Staff or other participants during the 6-week WWC Healing Sessions and land-based activities and events. Failure to comply will result in immediate dismissal from WWC Treatment.
2. In the event that a WWC participant becomes physically aggressive or threatening towards staff or other participants, the WWC will contact RCMP to remove the participant from the premises.
3. WWC has healing sessions with planned activities- please follow the activities as scheduled.
4. During the settling in period- there will be no phone calls or visitors for 10 days.
5. Smoking, beverages and food are allowed only in designated areas.
7. Participants are not to purchase energy drinks during their stay at WWC.
8. Cell phones and electronics are not permitted.
9. TV is a privilege and will not be allowed during sessions; failure to comply with the rules will result in a verbal warning.
10. Restricted content on television, radio, or music playing devices: ie. Party music, shows that depict drugs, alcohol, and/or violence.
11. Participants will not ask staff to use office phones for any reason; no exceptions.
12. Sexual relationships are not permitted at any time between participants/staff during your stay.
13. Participants are expected to be awake by 7am each morning; except on weekends. Participants should be awake by 8am.
14. Lights are out every evening by 11pm from Sunday to Friday. Lights are out at 12pm on Saturdays.
15. TV, radio or any other music should be off by 11pm each night.
16. Participant outings are a privilege and can be taken away in the event that a WWC Wellness Worker finds it necessary to do so.

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Updated: May 28, 2024

17. Participants are responsible for making their beds and cleaning their bedrooms each morning and replacing their sheets every Saturday.

18. Participants will be assigned specific housekeeping duties which will be rotated weekly; failure to comply could lead to a verbal warning and will be documented in a participant's chart.

19. Participants are expected to attend all WWC healing sessions and activities, including AA meetings, outside meetings, recreation and other group activities.

20. WWC rooms are designated for male and female; men are not allowed in woman's rooms and vice versa. Gender identity will be considered.

21. During treatment, participants are not allowed to visit homes or relatives.

22. Respect one another's customs and beliefs.

23. Dress properly and accordingly while in treatment.

24. Staff are not responsible for any items left at WWC.

25. Violence or threats against staff will not be tolerated; failure to comply could lead to automatic discharge of treatment.

26. Alcohol and drug use is prohibited. If the participant is suspected of using any substances, a drug test will be done. If the result is positive- immediate discharge will occur.

29. Rooms will be inspected by staff on a regular basis.

30. **NO SWEARING** allowed at any time during your stay; you will be given 2 warnings; A third warning is ground for dismissal from WWC.

31. If three verbal warnings are given (due to not following any of the House Guidelines)- and after the third warning- a participant will be involuntarily discharged from WWC.

I understand and agree to follow these House Guidelines.

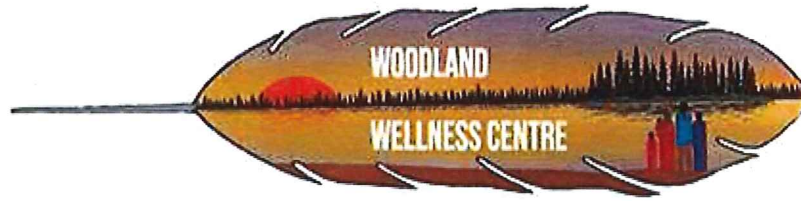
Participant Signature: _____ Date: _____

Witness: _____ Date: _____

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Updated: May 28, 2024



Woodland Wellness Treatment Centre

Admission Policy

1. The applicant must be eighteen years old or older to attend services.
2. Participants must be sober for a minimum of 7 days prior to treatment at WWC.
3. In the event that WWC staff suspects drug/alcohol use, a drug test will be done; if WWC finds that a participant has used the participant will be discharged from treatment.
4. Participants will be on a 10-day settling in period; there will be no visits or phone calls during this first 10 days in treatment.
5. All referral agents are responsible for transportation to WWC. Transportation arrangements to and returning back to their community, will be the responsibility of the community or referral agent. If the participant uses their own means of transportation; WWC will require the keys to be turned in upon arrival.
6. WWC is responsible to provide inpatient treatment services to all Lac La Ronge Indian Band communities. (Stanley Mission, Hall Lake, Grandmothers Bay, Sucker River, Little Red and La Ronge) If full capacity is not met, WWC will accept other First Nations applicants, Non-Status, Metis and Non-First Nations from anywhere in Canada.
7. Participants must arrive on the scheduled intake date; no later. If you are travelling from a distance greater than 4 hours, ensure to arrive prior to 3:30pm.
8. **The admission policy, house guidelines, application form, medical examination form and conditions of Agreement form need to be signed and completed by the participant and the referral agent and then submitted for screening to WWC.**
9. The applications will be reviewed and approved by the WWC Team.
10. A letter of confirmation of acceptance is necessary in order to be admitted into WWC
11. The participants and/or referral agent(s) are responsible to arrange legal, medical and other personal matters to be taken care of before or after WWC treatment. No exceptions.
12. Prescribed medications and over the counter drugs will be retained by WWC. Preferably blister/bubble packed.

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Updated: May 28, 2024

13. WWC is required to inspect the participant's belongings upon admittance.

14. The referral agents are responsible for the participants prior to, during treatment and upon discharge. RAs are also recommended to provide follow-up with participants 1 week, 3 months, 6 months, 1 year and +2 years after discharge.

15. WWC has the right to discharge any participant that does not want to follow the treatment plan or policies of WWC.

16. A participant's transportation to WWC cannot leave until a drug test and Covid test is completed. If either test is positive the participant will return with their transportation to their community.

I understand and agree with the Admission Policy.

Participant Signature: _____ Date: _____

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