PHOENIX CENTRE TRANSITIONAL HOUSING PROGRAM

Located in Surrey, British Columbia, the Phoenix Centre Transitional Housing Program provides safe, structured housing to enhance recovery support services for up to a maximum of two (2) years to individuals who are in recovery or are homeless, at risk of homelessness or in unsafe housing. We serve individuals over the age of nineteen (19) who are initiating lifestyle changes, developing skills and finding long term stability (housing, education, employment, and quality of life) to continue their recovery experience after treatment.

Our program may be a fit if you are:

- Managing daily living independently
- Active in your recovery and seeking housing in a substance free living environment.
- Engaging in supports that align with your wellness goals.
- Working towards housing, education, employment or other long-term goals.
- Completing a 90-day intensive live-in treatment program (or a combination of an intensive live-in treatment program and outpatient mental health and/or substance use services for 90-days) within thirty (30) days of the application.
- Able to pay program fees (i.e., income assistance or self pay).
- Below the maximum gross household income of $58k as per the Housing Limits (HILs) published by BC Housing.

Please review our "Frequently Asked Questions" document which can be found on our website, for additional information about the program and application process, including Admission Criteria, Exclusion Criteria and accepted documentation for proof of income. In some instances, our program may identify that we cannot adequately and/or safety support an individual who has been referred. Each application will be reviewed on a case-by-case basis.

If you have any questions or concerns, or wish to submit your completed referral form, please reach out to:

thadmissions@phoenixsociety.com
Telephone: 604-583-7166 ext. 2222
Fax: 604-951-1191

Please note we require all supporting documentation, including proof of income for your referral to be considered complete.

All referrals are to be completed by a referral provider in collaboration with the applicant. A referral provider can be a counsellor, social worker, physician, psychiatrist, community mental health and/or addiction team provider, psychologist, nurse practitioner or case manager.

Please review and complete the checklist below as you prepare your housing application to ensure you meet all eligibility and program fit guidelines, your application is filled out in full, and that you have included all required supporting documents for proof of income.

IMPORTANT: Applications submitted without the required supporting documents (if applicable) will be considered **incomplete** and will not be added to the Transitional Housing waitlist.

APPLICATION CHECKLIST:

- ☐ Completed all sections of the application in full
- ☐ Reviewed "Phoenix Centre Transitional Housing Additional Information (found on website)
- ☐ Ensured eligibility criteria is met
- ☐ Connected to community support(s)
- ☐ Signed 'Voluntary Consent for Release of Information' document (see below)
- ☐ Attached relevant documentation (i.e., legal, medical, etc.)
- ☐ Identified emergency contact(s)
- ☐ Proof of income

PROOF OF INCOME ACCEPTED DOCUMENTS:

Income Source	Details
Employment	• At least three (3) current consecutive pay stubs reflecting gross average earnings; or • Letter from employer or Record of Employment stating gross monthly salary.
Income Assistance (including PWD)	• MSDPR Confirmation of Income form (HR3639) • Ministry Release of Information stating support and shelter, or • At least three (3) current consecutive months of bank statements showing IA deposits.
Employee Insurance	• Letter from Service Canada stating weekly entitlement before taxes; or • Copy of detailed account statement from Service Canada website; or • At least three (3) current consecutive months of bank statement showing EI deposits.
Pensions and Disability Income (excluding income assistance/PWD)	Includes: OAS/GIS, Private Pensions, Foreign Pensions, Superannuation, RRIF, WCB, LTD and others • Current Letter of Entitlement from all pension providers; or • At lease three (3) current consecutive months of bank statements showing pension deposits.
Alimony or Family/Friends/ Community Support	• Confirmation of alimony support from court orders or other legal documentation. • Three (3) consecutive bank statements showing the support deposits; or • Written documentation from the person(s) providing the alimony or support

APPLICATION:

Referral Date:		Date added to waitlist (internal)	

CLIENT INFORMATION

Legal Name:		Preferred Name:		Preferred Pronoun:	

Date of Birth: mm/dd/yyyy		Age:		Gender:	Select

Social Insurance Number:		Personal Health #:	

Current Address:		City:	
Province:		Postal Code:	

Phone:		Email:		Preferred Method of Contact:	Select

Do you have minor child(ren)?	Select	If under 19, what are the child(ren) current living situation?	

If applicable, what visit(s) are available for you with your child(ren)?		Pregnant?	Select

Do you have any pet(s)?	Select	If yes, how many and what kind?	

COMMUNITY SUPPORTS

Referral Provider:	Name:			Organization:		
	Phone:		Email:		Fax:	

Primary Community Support*	Name:			Organization:		
	Phone:		Email:		Fax:	

* *(if different from Referral Provider)*

Physician:	Name:		Clinic Name:			
	Phone:		Email:		Fax:	

Psychiatrist:	Name:		Clinic Name:			
	Phone:		Email:		Fax:	

Community Pharmacy:	Name:		Address:			
	Phone:		Email:		Fax:	

Other Community Support(s):	Name:		Relationship:			
	Phone:		Email:		Fax:	

INCOME AND MEDICAL PHARMACY COVERAGE

Income Source:	☐ MSDPR (IA) ☐ PWD ☐ CPP/CPPD ☐ Employment ☐ Other Income ☐ Employment Insurance ☐ Long Term Disability	If employed, annual income:	

Medical/Pharmacy Coverage:	Type:		Policy No.	
	ID No:		Third Party Insurer:	

CULTURAL INFORMATION

Do you identify as an Indigenous Person *(First Nations, Metis, Inuit)*	Select	If YES:	Select

Ethnicity:		Primary Language:	

Interpreter Need?	Select	Provide details:	

Please describe any cultural, spiritual, religious practices or ceremonies that will support your wellness in program:

RECOVERY SUPPORT AND GOAL PLANNING

What has been helping you in your recovery journey so far? How can Phoenix continue to support your recovery?

Are there any behaviours, barriers, challenges or activities that sometimes feel difficult to manage and may affect your recovery?

Please list your recovery goals *(i.e., employment, social supports, legal, housing, medical, physical, mental health, substance use & recovery, life skills, etc.).*

HOUSING

Why is this program being considered at this time? How did you hear about our program?

What barriers exist in accessing safe and supportive housing in your community?

Please identify any anticipated challenges and supports needed for success in the program.

Current Housing:	☐ Own home ☐ Rent ☐ Shelter ☐ With family/friends ☐ No fixed address ☐ Subsidized Housing ☐ Other please describe below	Stability:	Select
		Safe:	Select

Please describe current plan for housing if a suite is not available immediately:	

Is there a post discharge housing plan?	Select	If YES, please describe:	

What housing referrals have already been completed? Please list below			
Name:		Referral Date:	
Name:		Referral Date:	
Name:		Referral Date:	

HISTORY OF SUBSTANCE USE CONCERNS

Please indicate substances you have used or have a history of using:
☐ Alcohol ☐ Amphetamines ☐ Benzo ☐ Cannabis ☐ Cocaine ☐ Crack Cocaine ☐ Crystal Meth ☐ Ecstasy ☐ Fentanyl ☐ GHB ☐ Hallucinogens ☐ Heroin ☐ Inhalants ☐ Other Opioids ☐ Tobacco/Nicotine ☐ Other *(specify)*

Please List the Top Three (3) Substances Primarily Used and Current Pattern of Usage					
Substance	Method of Use	Date Last Used	# Days used in last 30 days	Average amount used daily	Age at first use

HISTORY OF PROCESS CONCERNS

Please select any of the following that you feel are current or have a previous history with:
☐ Gambling ☐ Gaming ☐ Internet ☐ Pornography ☐ Shopping ☐ Sexual Activity ☐ Shoplifting ☐ Other *(specify)*

If YES to any above, provide a brief description, including anticipated challenges and supports:

SUBSTANCE USE TREATMENT HISTORY

Current Program:		Expected date of completion:	

Have you previously been connected to a Phoenix Program?	☐ Stabilization ☐Treatment ☐ Rising Sun ☐ The Nest ☐ Transitional Housing	Expected date of completion:	

If not completed, please provide details:

Previous Live-In Treatment, Second Stage Housing Programs or Day Treatment Programs attended:		
Program:	Date(s) Attended:	Completed:
		Select
		Select
		Select
		Select

If no previous live-in treatment history, why?

Past or Present Counselling Services Attended:

Past or Present Community Support Groups Attended *(i.e., AA, NA, SMART Recovery, etc.):*

MEDICAL HEALTH HISTORY

Do you have any Allergies *(environmental, food, and/or medication)?*	☐ YES ☐ NO

If YES, please provide a brief description and type of reaction(s) and treatment needed:

Independent with activities of daily living (ADLs):	☐ YES ☐ NO

If NO, please provide details:

Past overdose history:	☐ YES ☐ NO

If YES, was it:	☐ Accidental ☐ Intentional

If YES, please provide date(s):

Does the Client have a history of disorder eating?	☐ YES ☐ NO

If YES, is the disordered eating still ative?	☐ YES ☐ NO

If YES, please provide details and date last active:

Please provide any other heath conditions, diagnoses or disabilities we should be aware of.

Please provide any hospitalization(s) due to medical concerns:

MENTAL HEALTH HISTORY

Please indicate mental health conditions self reported or diagnosed (historically or current):
☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Neurocognitive Disorder ☐ Neurodevelopmental Disorder ☐ Obsessive Compulsive Disorder ☐ Personality Disorder ☐ Psychotic Disorders ☐ Substance Related Disorders ☐ Trauma & Stressor Related Disorders ☐ Other *(specify below)*

If YES, provide a brief description, including anticipated challenges, diagnosed/self-reported, historical/current, impact, etc.

Please describe treatment you have received, or are currently receiving for your mental health wellness:

Hospitalizations due to mental health concern(s):

CURRENT MEDICATIONS

Please attach a list of medications or write the information below
i.e., Pharmanet print out, copy of

Medication & Dose	Date Started	Prescriber

Antiretroviral (ARV) Therapy:	Select	OAT Medication:	Select	Long-acting injectable anti-psychotic medication:	Select

Date of next required dose:	

SAFETY ASSESSMENT

Self Harming Behaviours:	Select	Suicidal Ideations:	Select	Suicide Attempt(s):	Select

If YES to any of the above, please provide details *(dates, situational factors, etc.):*

Safety plan *(e.g., stressors, warning signs, coping strategies, supportive measures by self or staff, etc.).*

Sex Work	Select	Sexual Offences Involving Minors:	Select	Arson/Fire Setting	Select

Interpersonal/Domestic Violence	Select	History of Aggression	Select	If yes	Select

If YES to any of the above, please provide detailed information about the safety concern and effective interventions:

LEGAL

Are you on supervised probation?	Select	Are you currently on bail?	Select

Bail/Probation Officer Name:		Office Address:	
Phone:		Fax:	

Are there any legal conditions that we need to be aware of to support your stay? Please note below and attach documentation.

Can you be supported in program in reference to recent / past charges? *(refer to possible exclusionary & exclusionary criteria)*

Status under the BC Mental Health Act *(if applicable, please attach to application)*	☐ Certified ☐ N/A ☐ Extended Leave Expected completion or review date:

Upcoming Court Date(s)		Location / Virtual:	Select

EMERGENCY CONTACT

Please note that the primary community support AND the emergency contact person will be notified in the event of an emergency, the resident leaves on short notice or an urgent discharge is required.

Contact Name:		Relationship:	
Phone No:		Email:	

Is there a Substitute Decision Maker, Power of Attorney or Trustee:	Select		
Contact Name:		Relationship:	
Phone No:		Email:	

If YES, please provide a brief description *(i.e., finances, treatment decisions, etc.):*

Are supporting documents attached?	Select

VOLUNTARY CONSENT FOR RELEASE OF INFORMATION

The Phoenix Society handles information in accordance with the Personal Information Protection Act (British Columbia). Information about this act is made available at all Phoenix Society sites. In addition, the Phoenix Society will advise persons served of their rights regarding privacy and confidentiality. All personal information provided to the Phoenix Society will be treated with the utmost confidentiality.

Information about persons served will be shared between in the Phoenix Society in situations where there may be a duty to warn, a safety concern, or a child protection concern. In cases where there is an intra-Phoenix Society referral, information will be shared between services of the Phoenix Society. The Phoenix Society will only release personal information with the written permission of the person served to parties external to the Phoenix Society for the purpose of that person's care management in the program, including, but not limited to, the following:

- Ministry of Social Development and Poverty Restriction
- Ministry of Health
- Other agencies involved with the person's care management.

Information may also be released to agencies or individuals conducting research on behalf of Phoenix Society. This will only be done undersigned agreements to maintain confidentiality and to ensure that no personal identifying information is made public.

There are exceptions to an individual's right to confidentiality. Phoenix Society has a duty to report in the following circumstances.

- The individual is planning to harm themselves or others
- Children, the elderly or a vulnerable person is in need of protection
- Phoenix Society receives a subpoena to attend court, be a witness in court or release information in response to a subpoena. In this case, only the required information stated on the subpoena will be released, which in some cases may include client files.

In the event of an emergency, such as a medical emergency or a missing person, staff will be required to release personal information that is necessary to assist emergency services (i.e., paramedics, police, etc.) to respond to the situation. Personal information that may be released includes, but is not limited to, an individual's legal name, identifying features (i.e., hair colour, weight, height, etc.), medical information and/or picture.

Please indicate below your consent for Phoenix Society to share your personal information.

NAME	PHONE NUMBER/EMAIL	SPECIFY LIMITATIONS FOR INFORMATION SHARED
Counsellor		
Physician		
Psychiatrist		
Social Worker		

Probation / Parole Officer		
MCFD Worker		
Other		

By signing below, I consent to the following:

This referral is being submitted in consideration for Phoenix Society's Transitional Housing Program. The information in this referral and any supporting documents is being released and shared between my community care team and the Phoenix Society. As part of my application, I have provided accurate information to the best of my ability, voluntarily agree to attend the program and understand that this is a substance free program. I have carefully reviewed the above information and the "Additional Information FAQ" document on Phoenix Society's website. Any questions or concerns have been addressed to my complete satisfaction.

Applicant Name:		Signature:		Date:	

Referral Provider Name		Signature:		Date:	