MAWIOMI TREATMENT SERVICES INC.

85 SCHOOL STREET, GESGAPEGIAG, QC G0C 1Y1
TEL: (418) 759-3522 FAX: (418) 759-3048

Greetings!

I am respectfully submitting Mawiomi Treatment Services Inc.'s referral application forms and the treatment cycle schedule for 2021.

To better acquaint you with our Center: Mawiomi Treatment Services Inc. is a seven bed residential treatment center situated in the First Nation Mi'gmaq territory of Gesgapegiag. Our program duration is six weeks and offers its residents with individualized healing plans that is developed using the holistic approach. Mawiomi Treatment Services encourages and utilizes First Nation traditional values, beliefs and morals. In addition, we provide individual counseling, group circles, videos, discussions and teachings. We also host A.A. & N.A. meetings.

Mawiomi Treatment Services is honored to announce that since 2020 we have been supporting our graduates in their transition back into their communities. We have added an Aftercare Counselor and they will work with Referrals in developing a post-treatment plan. The Aftercare counselor will follow the Graduates for up to 18 months post-treatment.

Mawiomi Treatment Services Inc. is very proud to have employees that are dedicated and committed in the healing of our people. Should you require additional information please contact our Programs & Services Advisor.

In Unity and Strength,

Gloria Syvret
Executive Director

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MAIN OFFICE : TEL: (418) 759-3522 FAX: (418) 759-3048

OUTPATIENT OFFICE : TEL: (418) 788-5135 FAX: (418) 788-2945

Intake Schedule 2021

Intake Day | Graduation | End of Cycle | Staff Self Care & Housekeeping | Vacation

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						2
3	Admin/Training Week					9
10	Admin/Training Week					16
17	Admin/Training Week					23
24		26	27	28	29	30
31	Cycle 1 - Jan.25 to Mar. 03					

February

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

March

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2				6
7	Admin/Training Week					13
14		16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			
Cycle 2 - Mar.15 to Apr. 21						

April

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20				24
25	Admin/Training Week					

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2		4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	Cycle 3 - May.03 to Jun. 09				

June

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8				12
13	Admin/Training Week					19
20		22	23	24	25	26
27	28	29	30			
Relapse Cycle 4 - Jun.21 to July 14						

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13				17
18						24
25						31
Vacation - Jul. 19 to Aug. 6						

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1						7
8	Admin/Training Week					14
15		17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				
Cycle 5 - Aug.16 to Sep.22						

September

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21				25
26	Admin/Training Week					

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						2
3		5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	Cycle 6 - Oct.04 to Nov.10					

November

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9				13
14	Admin/Training Week					20
21		23	24	25	26	27
28	29	30				
Relapse Cycle 7 -Nov.22 to Dec. 15						

December

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14				18
19						25
26						
Christmas holidays Dec.20 to Jan.3						

1. **Intake forms must be received by our office, fully completed (medical included) 5 days prior to the intake day.**
2. Residents are expected to arrive during the afternoon on intake day. Late arrivals will be considered for those travelling long distance.
3. **Residents are allowed communications (incoming & outgoing) only after two full weeks of treatment.**
4. The duration of the residential program is SIX (6) weeks. Referral workers who wish to be involved in the development of the aftercare plan are invited to communicate with the residential counselors and may also attend their client's graduation ceremony.

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To: All Referrals

From: Gloria Syvret
Executive Director

Subject: Intake Applications

All applications must be completed and received fourteen (14) days prior to Intake Day of the upcoming cycle. All applications received after this date will be placed on the waiting list. These changes are mandatory due to the high demand for service.

When we receive an application it will be reviewed by the Programs & Services Advisor for any missing or questionable information. If the application is complete then the potential client will be contacted for a phone interview. The phone interview will take less than 30 minutes. This part of the intake process is mandatory therefore they must provide a valid phone number on the application or make themselves available with the referral to conduct the interview.

Once that information is documented, the Clinical Team will then decide based on priority needs and readiness to change who will receive an acceptance letter.

On behalf of everyone at Mawiomi, we would like to take this time to thank you for your continued support.

Note: Please forward all applications to:

Jim Skinner
Program & Services Advisor
Mawiomi Treatment Services Inc.
85 School Street, Gesgapegiag, QC G0C 1Y1
Tel: (418) 759-3522 ext. 208
Fax: (418) 759-3048
Email: jim@mawiomi.org

DO NOT FAX APPLICATION UNTIL IT IS COMPLETE

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Client Preparation

Referral sources are requested to prepare clients for Mawiomi Treatment Services. In particular, make sure the client is aware of the following requirements:

a) All clients must be drug-free and/or alcohol free (7 days) in order to deter any incapacitating withdrawal symptoms; Detox may be required if less than 7 days prior to admission.

b) Clients must be willing to abstain from all mood altering substances for the duration of the program.

c) Clients must be able and willing to look after and be responsible for themselves. No medication (unless prescribed by a doctor for medical use) or custodial supervision is provided at Mawiomi Treatment Center. Clients must bring sufficient money to purchase personal items such as toiletries, cigarettes, etc., and should bring a minimum of three changes of clothes.

Medication: All medications require a prescription (including any over the counter medications such as Tylenol, Cough syrup, etc). The client must arrive with the prescription and/or prescribed medications in bubble packs. Any medications in containers without prescriptions will not be dispensed.

***Client maybe required to pay for their medications at the pharmacy, Mawiomi will not incur the cost of any medications.**

Procedures for Bag/Garment Check:

All bags will be checked every time upon arrival to the Center, whether it is upon admittance or after an outing.

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Personal Items You Should Bring

Absolutely Necessary items	Items to bring (if desired)
Personal Identification	Tobacco
Medicare Card	Sage
Status Card	Sweet Grass
Birth Certificate (if you have no ID)	Eagle feather
Parole/Probation Certificate	Cedar
Return Travel Tickets	Ribbon Shirt/Dress (Graduation)
Money for personal items	

Clothing

Minimum of: Four separate changes of clothing (pants, shirt, and blouses)
- Underwear and socks
- Gym clothes
- Pajamas and/or night gown
- Shoes, running shoes and slippers
- Windbreaker
- Winter jacket, gloves, hat, mitts and scarf – Winter Season
- Boots – Winter season
- Sweaters – Winter season

Toiletry Articles:
- Soap / body wash
- Shampoo and conditioner
- Toothbrush and toothpaste
- Shaving cream and razors
- Hair brush / comb
- Sanitary napkins / tampons
- Deodorant
- Hair dryer and curling iron
- Hair spray (pump only)

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INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

ADULT INTAKE APPLICATION

A. General Information

Surname:	First Name:		Nickname:	S.I.N #:
Date of Birth: (DD/MM/YYYY)	Age:	Sex:	Provincial Heath Card Number:	Expiry:(YYYY)
Address:		Home Telephone:	Cellphone:	
Education: ☐ Some high school ☐ Completed high school ☐ Post-secondary (Cegep, Univ., D.E.P. etc.)			Employment Status:	
Treaty Number:		Band Name:		
Emergency Contact Name:		Telephone:	Relationship:	

B. Family/Relationships

Marital Status:	How long?
Does Client have dependent children?	☐ Yes ☐ No
If yes, do they have access to adequate childcare while in treatment?	☐ Yes ☐ No ☐ N/A
Are any children under youth protection or social services?	☐ Yes ☐ No ☐ N/A ☐ Voluntary Measures ☐ Court Ordered
Does the client have other dependents?	☐ Yes ☐ No

Provide information on client's children or other dependents:

NAME	AGE	RELATIONSHIP

What is your family's support towards you seeking treatment?

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C. Legal Status

Has client been court ordered to attend treatment?	☐ Yes ☐ No
If yes, provide details (include copy of probation order if applicable or available):	
Is client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temp Absence Order
Does the client have any charges pending?	☐ Yes ☐ No
What were the charges?	Sentenced imposed?
If yes, please explain:	Court date:

D. Treatment History

Has client participated in a non-residential/community-based substance abuse and/or mental health program?	☐ Yes ☐ No
If yes, what type of program?	
Has client participated in a residential treatment program before?	☐ Yes ☐ No
If yes, please provide information on previous treatment experience:	

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Has the client been able to be sober in the past?	☐ Yes ☐ No
If yes, how long?	What did they do to remain sober?
When was the last time they used before filling out this application?	

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What substances did they use?		
Substance	Date when last consumed	Amount consumed

E. Withdrawal Symptoms

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptoms		Describe
Blackouts	☐ Yes ☐ No	
Hallucinations	☐ Yes ☐ No	
Nausea/Vomiting	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
Shakes	☐ Yes ☐ No	
Delirium Tremens (DT)	☐ Yes ☐ No	
Ever experienced DT's?	☐ Yes ☐ No	

F. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction		Describe
Gambling (slots, cards, keno, bingo, etc.)	☐ Yes ☐ No	
Eating (obesity, anorexia, bulimia, etc.)	☐ Yes ☐ No	
Sex (cheating, etc.)	☐ Yes ☐ No	
Internet/Cellphone	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

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G. Other Issues/Needs	
Does client have any cultural/spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does client have any literacy or learning difficulty we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐ Yes ☐ No
Does the client understand there is an expectation that they will be alcohol and drug free for at least 72 hours prior to admission to residential treatment?	☐ Yes ☐ No
Personal strengths of the client?	

H. Information to be completed by the referral			
Name:	Occupation:	Agency:	
Address:			
Telephone:	Extension:	Fax:	
Has the client completed four pre-treatment appointments?	☐ Yes ☐ No If yes, please indicate dates below:		
Date 1:	Date 2:	Date 3:	Date 4:
Will you continue to see the client once they have completed treatment?			☐ Yes ☐ No
In your assessment, which best describes the client's level of dependency?			
☐ Chronic	☐ Acute	☐ Moderate	☐ Experimenting
Does the client recognize that they have an alcohol and/or drug dependency?			☐ Yes ☐ No
In your assessment what stage of readiness to change would you place your client? ☐ Pre-contemplation ☐ Contemplation ☐ Determination ☐ Action ☐ Maintenance			

Referral Agent Signature _____ Date _____

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Consent for Treatment & Release of Information

I, _____ have agreed to enter the Mawiomi Treatment Centre, in the First Nation community of Gesgapegiag, QC to treat my Alcohol /Drug dependency problem.

I understand that in order for clients and staff to work effectively, the treatment program will include the following:

a. Counselling assessments – Educational sessions, one on one sessions, and aftercare planning (which includes participation in support groups).
b. Having contact with referral resources
c. Maintenance of confidential client records. Including the AMIS System, which include transferring of my AMIS Files between Centres.
d. The reporting of mandatory reports, this will include the DUSI-R and the NWA.
e. On-site surveillance Equipment.
f. And will include random room searches when staff are directed by the Programs & Services Advisor and/or Executive Director.

I understand that if I need medical attention, the staff will make sure that proper personnel will attend to me, (and/or) I will be transferred to an appropriate facility. It may also include needing to return home if medical issues take precedence over treatment.

I understand that Mawiomi has rules, treatment expectations, whereby all residents have to abide by.

I understand the explanation of the above and therefore, consent to undergo treatment.

Date: _____ Signature: _____

Date: _____ Witness: _____

Referral Agency & Contact Person _____

Telephone # _____

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Mawiomi Treatment Center Travel Policies

- Confirmation of travel arrangements to and from the treatment center to the client's home community of residence on or off reserve must be forwarded to the Treatment Center prior to arrival.

- Clients should arrive at the Treatment Center with prepaid travel arrangements, such as airline tickets, bus tickets or an outline of ground transportation.

- All prepaid travel of clients will be provided to Treatment Center staff upon arrival and will only be returned to the client at the completion of treatment. **Clients that do not complete treatment will not be reissued their prepaid travel arrangements if the Center does not approve the early departure.**

- The Treatment Center or referring community is not responsible for clients that do not complete their treatment program due to the client being terminated by the staff or if the client decides to leave on their own for unjustified reasons.

I, the undersigned have read and understand the travel policies and therefore am aware that Mawiomi Treatment Services and my sending community are not responsible should I be terminated before graduation or should I decide to leave treatment before graduation.

Date: _____ Client Signature: _____

Referral Agent: _____

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I. Medical Assessment

Client's Name:		D.O.B. (m/d/y):	
Health Card Number:		Blood Pressure:	Pulse:
Vision:		Hearing:	
Height:		Weight:	
Cardiovascular:	Chest:	Allergies:	Abdomen:
Present Health Problems:			
Past Health Problems:			
Is this client able to participate in physical recreation? ☐ Yes ☐ No If no, please explain:			

Current Medications	Dosage	Since when?

TB TEST MANDATORY	TB Skin Test (d/m/y):	Result:
If TB results are of a high reading or not available please provide:	Chest X-ray (d/m/y):	Result:

If you are aware of any difficulties that we should consider in treatment, please provide details (i.e. anxiety,
suicidal ideation, depression):

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Provide the following information about clients health status:		
Mental Illness		Describe
Been diagnosed with a mental illness?	☐ Yes ☐ No ☐ Unknown	
Currently being treated?	☐ Yes ☐ No	
Currently on mental health medication?	☐ Yes ☐ No	
Taking medication consistently?	☐ Yes ☐ No	
Any previous suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No	
Name of Psychiatrist/Psychologist (if applicable):		

_____ _____ _____

Physician's Name (Printed) Telephone # Date

_____

Physician's signature