VOLUNTARY PROGRAM PARTICIPATION AGREEMENT

I understand that Ka-Na-Chi-Hih is a voluntary treatment program; therefore, I am willing to attend treatment and comply with all treatment-related programming.

I am aware that should I choose to not participate in programming or follow the rules at Ka-Na-Chi-Hih, it could result in my discharge.

Client Name: ______________________________
(please print)

Client Signature: ______________________________ Date: ____________________
(mm/dd/yyyy)

Witness Name: ______________________________
(please print)

Witness Signature: ______________________________ Date: ____________________
(mm/dd/yyyy)

PRE-ADMISSION AGENT AGREEMENT

It is the policy of the Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre that:

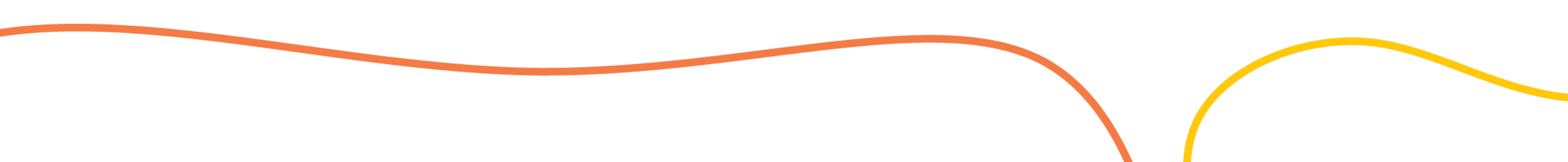
- Any person for treatment must be substance-free for at least 72 hours prior to admission.
- The referring agent is responsible for making all travel arrangements and designates an appropriate escort for the safety of the client to and from Ka-Na-Chi-Hih. The referring agent MUST fax a copy of the travel itinerary or notify the intake department a minimum of 24 hours prior to the client's arrival.
- The referring agent contacts Ka-Na-Chi-Hih once a month to review the progress of the client.
- The client may be returned to the referring agent if there is non-compliance with the treatment program.
- The referring agent understands that Ka-Na-Chi-Hih has a 30-day assessment period, if the Treatment Team is unable to provide the care required to meet the specific needs of the client.
- It is the responsibility of the referring agent to ensure that all information provided is correct. Any false, misleading, fabricated, or withheld information may lead to a client's dismissal from the treatment program due to inaccurate representation.

I understand the policies of Ka-Na-Chi-Hih and I agree to the responsibilities as the referring agent.

Agent Name: ______________________

Agent Signature: __________________________ Date: ______________________

Title: ______________________ Organization: ______________________________



AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, ______________________________,
(Client Name) (D.O.B – mm/dd/yyyy)

of ____,
(Address)

hereby do consent and authorize to the release, disclosure, and/or transmittal of the following information:

treatment updates; obtaining and releasing information; medical, dental, legal, educational, and family history; identification; and any other areas of information to assist with treatment planning as necessary.

From: court workers, parole or probation officers, lawyers, social workers, medical or psychiatry, practitioners, educators, NNADAP workers or other relevant professionals.
(Agency Providing Information)

To: Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre
(Agency or Individual Receiving Information)

For the purpose of: treatment and providing appropriate services to client.

I understand the confidential nature of this information and the purpose for the release, disclosure and/or transmittal of the information noted above. This authorization will be valid for a period from the date of signing until 1 year from discharge or completion of the program.

Client Name: ______________________________
(please print)

Client Signature: ______________________________ Date: ____________________
(mm/dd/yyyy)

Witness Name: ______________________________
(please print)

Witness Signature: ______________________________ Date: ____________________
(mm/dd/yyyy)

CLIENT RULES & EXPECTATIONS

1. Clients shall refrain from using all mind-altering substances while on Ka-Na-Chi-Hih property.
2. Clients will refrain from possessing, using, or distributing any form of contraband while at Ka-Na-Chi-Hih.
3. Disruptive, violent behaviour will not be tolerated.
4. Clients are not permitted any weapons (guns, knives, crossbows, restricted or prohibited weapons) on the premises of Ka-Na-Chi-Hih.
5. Clients are expected to participate in all aspects of the program and related activities.
6. Willful damage to Ka-Na-Chi-Hih property or others' personal property will not be tolerated.
7. Clients will respect the privacy and boundaries of both clients and staff.
8. Clients will behave in a responsible and respectful manner on and off Ka-Na-Chi-Hih property.
9. Clients are not permitted to sell, trade, gift, or barter personal items.
10. Food and beverage will only be allowed in designated areas.
11. Clients will not be allowed to access unrelated treatment areas without staff supervision.
12. Smoking will be allowed in designated areas during scheduled times. Clients will be accompanied by staff during smoke breaks.
13. A leave of absence, without discussion or permission, for three or more days will result in discharge from the program. If a leave of absence is due to unforeseeable circumstances, please contact Case Manager, Natasha Moro-Godzik at nmorogodzik@kanachihih.ca or Clinical Lead, Marinna Read at mread@kanachihih.ca to make arrangements for make-up sessions.
14. All cellphones, cigarettes, medications, and personal items, unless deemed necessary, will be placed in individual bins and double locked during the duration of the day program.
15. At no time will clients engage in teasing, bullying, and/or harassment of any kind.

A client breach of the rules can be immediately discharged at the discretion of the Ka-Na-Chi-Hih team, Treatment Manager, and/or Chief Executive Director.

I have read and agree to the above rules and expectations, and I agree to abide by them.

Client Name: ______________________________

Client Signature: ______________________________ Date: ________________
(mm/dd/yyyy)

Witness Name: ______________________________

Witness Signature: ______________________________ Date: ________________

(mm/dd/yyyy)

VIRTUAL REALITY PROJECT OVERVIEW & CONSENT FORM

Therapeutic Approaches Utilizing Virtual Reality Therapy

Project Overview

Miigwech for partaking in our latest study on therapeutic approaches utilizing virtual reality. This study aims to explore the impact of therapeutic approaches while partaking in 24/7 treatment facilities and utilizing the virtual reality headset for aftercare interventions. Participants in this study will partake in therapeutic curriculum throughout their stay at Ka-Na-Chi-Hih and upon graduation, will be provided with a Meta Quest 2 headset to connect with their Virtual Reality Facilitator for aftercare interventions. The study will gather data on a variety of information such as amount of usage, comparing VR programming to traditional programming, and positive impacts on your well-being.

Participant Name	Date of Birth (mm/dd/yyyy)	Phone Number

Address	Email

Consent

I, ______________________________, voluntarily agree to participate in this project and hereby provide my informed consent. I have been given the opportunity to ask questions and have received satisfactory answers regarding this project.

<u>I understand the following:</u>

1. Duration of Participation: I will participate in scheduled VR programming during the rest of my stay at treatment. Upon graduation, I agree to take a Meta Quest 2 home and utilize it to connect with my VR facilitator for aftercare services.

2. Usage Frequency: I agree to use the headset a minimum of _________________________ (times/hours/minutes) per week while at home for aftercare.

*Please note, "Usage Frequency" represents the client's personal goal regarding the realistic time commitment they can dedicate to utilizing VR.

3. Data Access: My VR facilitator or researcher may access data recorded by the headset for the purpose of monitoring my participation and well-being. Data may also be accessed and utilized for program improvement and evaluation purposes.

4. Return of Equipment: Upon graduation, I will be provided package materials to return the headset via mail and I will return the headset to the Project Coordinator at the end of the three-week period.

5. Contact Information: If I am unable to use the headset or experience any issues during the study, I will contact the Project Coordinator at **(807) 700-9162**.

6. External Contact Information: If the VR Facilitator is unable to reach me through the VR headset or I wish to stop participating in the aftercare portion, I will provide the following external contact phone # or email that they can reach me at to coordinate the return of the headset ___________________________.

7. Risks and Benefits: I understand that there may be potential risks associated with extended VR usage, and there may be benefits in terms of improving well-being and understanding the technology better.

8. Confidentiality: I understand that my personal information will be kept confidential and will not be disclosed without my consent. Any survey responses or data collected will be de-identified (i.e. anonymous) and reported as a summary.

9. Voluntary Participation: I understand that my participation is entirely voluntary, and I can withdraw at any time without penalty. If you withdraw from the program, you can choose to have your data removed from any final reports.

Participants Signature: ___________________________ Date: ______________________
(mm/dd/yyyy)

Researcher / Project Coordinator

I have explained the project to the participant and have answered any questions they may have had.

Researchers Name: ___________________________
(please print)

Researchers Signature: ___________________________ Date: ______________________
(mm/dd/yyyy)